

# Harvard Medical Alumni Bulletin

July/August 1979



# Alumni Travel Program

## 1979-1980

This travel program is a special one for alumni of Harvard, Yale, Princeton, Cornell, Columbia, M.I.T., Brown, Dartmouth, Univ. of Pennsylvania and certain other distinguished universities and for members of their families. Designed for educated and intelligent travelers, it is planned for persons who might normally prefer to travel independently, visiting distant lands and regions where it is advantageous to travel as a group. The programs avoid the excessive regimentation normally associated with group travel, and are planned to include generous amounts of leisure time in the course of travel to allow for individual interests.

1979 represents the 15th year for the program. Additional new itineraries are in the planning stage as well, including the Galapagos, southern India, the People's Republic of China and other areas.

**REALMS OF ANTIQUITY:** Journeys into the past to explore the history and civilization of the ancient world. One itinerary of 17 days—**VALLEY OF THE NILE**—offers a comprehensive and authoritative survey of ancient Egypt. Starting with the British Museum and the Rosetta Stone, it visits the great monuments of ancient Egypt stretching along the Nile Valley from Memphis and Cairo to Abu Simbel near the border of the Sudan, including a cruise on the Nile from Luxor to Aswan. A second itinerary—**AEGEAN ADVENTURE**—covers the archeological treasures of classical antiquity in the lands of the Aegean in a journey of 23 days. It includes not only the historic sites of ancient Greece but also a rare view of ancient cities in Asia Minor, including the ruins of Troy, and in addition includes a cruise through the Aegean to Crete and other Aegean isles. A third itinerary—the **MEDITERRANEAN ODYSSEY**—is a 22-day journey which follows the spread of classical antiquity into the western Mediterranean: the splendid ruins of the classical Greek cities of Sicily, the historic ruins of Carthage, ancient Roman cities in North Africa, and the fortress cities of medieval Crusaders on the rocky isle of Malta.



**EAST AFRICA:** A distinctive program of safaris, ranging in length from 16 to 32 days, to the great game-viewing areas of Kenya and Tanzania and to the beautiful islands of the Seychelles. Led by experts on East African wildlife, the itineraries are carefully planned and comprehensive, offering an unusually complete opportunity to see and photograph the wildlife of Africa.

**THE SOUTH PACIFIC and EXPEDITION TO NEW GUINEA:** The island continent of Australia and the islands of New Zealand are covered by the **SOUTH PACIFIC**, 28 days, unfolding a world of Maori villages, boiling geysers, fiords and snow-capped mountains, ski plane flights over glacier snows, jet boat rides, sheep ranches, penguins, the Australian "Outback," historic convict settlements and the Great Barrier Reef. The primitive and beautiful world lying slightly to the north is seen in the 24-day **EXPEDITION TO NEW GUINEA**, a rare glimpse into a vanishing world of Stone Age tribes and customs. Includes the famous Highlands of New Guinea, with Sing Sings and tribal cultural performances, and the remote villages of the Sepik River and the vast Sepik Plain, as well as the North Coast at Madang and Wewak and the beautiful volcanic island of New Britain. For both tours, optional post-tour visits can be made to other islands of the southern Pacific, such as Fiji and Tahiti.

**CENTRAL ASIA AND THE HIMALAYAS:** A choice of 23 or 29-day itineraries exploring the vast historic and cultural heritage of India, the untamed Northwest Frontier region of Pakistan and the remote mountain kingdom of Nepal. Includes the famed Khyber Pass, imposing Moghul forts, sculptured temples, lavish palaces, formal gardens, the teeming banks of the Ganges, snow-capped peaks of the Himalayas along the roof of the world, picturesque cities and villages, the splendor of the Taj Mahal, and hotels which once were palaces of maharajas.

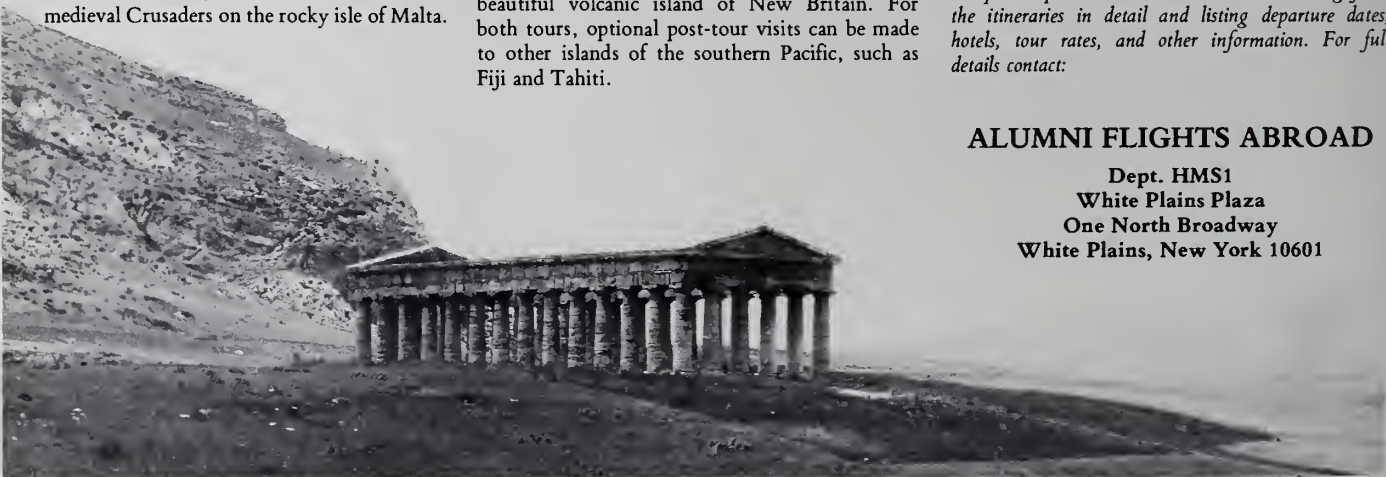
**THE FAR EAST:** Two itineraries which offer a fascinating insight into the lands and islands of the East. **THE ORIENT**, 29 days, is a classic tour of ancient and modern Japan, with special emphasis on the cultural treasures of Kyoto, and includes as well the important cities of Southeast Asia, from Singapore and Hong Kong to the temples and palaces of Bangkok and the island of Bali. A different and unusual perspective is offered in **BEYOND THE JAVA SEA**, 34 days, a journey through the tropics of the Far East from Manila and the island fortress of Corregidor to headhunter villages in the jungle of Borneo, the ancient civilizations of Ceylon, Batak tribal villages in Sumatra, the tropical island of Penang, and ancient temples in Java and Bali.

**SOUTH AMERICA:** An unusually comprehensive 28-day journey through the vast continent of South America, with dazzling pre-Columbian gold, ornate colonial churches and palaces, the ruins of the ancient Inca civilization, snow-capped peaks of the Andes, famed Iguassu Falls, the futuristic city of Brasilia, and other sights. Optional post-tour extensions are available to Manaus, in the heart of the jungle of the Amazon, and to Panama.

Prices range from \$2,215 to \$4,175 from U.S. points of departure. Air travel is on regularly scheduled flights of major airlines, utilizing reduced fares which save as much as \$600.00 and more over normal fares. Fully descriptive brochures are available, setting forth the itineraries in detail and listing departure dates, hotels, tour rates, and other information. For full details contact:

### ALUMNI FLIGHTS ABROAD

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White Plains, New York 10601





# Harvard Medical Alumni Bulletin

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# Overview

## Societies yield academic, social dividends

Cannon, Peabody, Henderson and Cabot are among the legendary figures of the faculty whose names are frequently invoked as representing the essence of the physician — erudition and humaneness. Those names will continue to resonate in the classrooms and laboratories of the Medical School through eponymous academic societies, formed to encourage closer and more productive relations between faculty and students.

The means by which knowledge is acquired has been a theme strongly espoused by Dean Tosteson. He first articulated his thoughts on the nature of the educational process shortly after arriving at HMS two years ago. On Alumni Day 1977 he asked: "Is it what we learned about the pathophysiology of congestive heart failure and the management of peptic ulcer? Or is it who we came to know and how those knowings influenced our attitudes about what and how to learn?"

"Academic societies" are an attempt at a creative solution to the perceived need for mutually greater social and intellectual dividends for both faculty and students. This educational innovation, however, was not devised to compete with the actual curriculum or with the Boylston Society, for example, which predominantly focuses on the presentation of student papers. Yet the societies are intended to be academically respectable, with a broad range, and to improve the quality of a medical education. Tying these two somewhat dissonant objectives into a cohesive and balanced format has required careful and creative planning by various faculty.

Dean Tosteson presented his ideas on incorporating academic societies into the HMS experience over a year and a half ago. The premise was to establish independent groups that would meet on a regular basis and in a social context to explore topics relevant to



**Lawrence J. Henderson '02 (1878-1942).** In an early essay, "The Fitness of the Environment," "L.J." Henderson examined the properties of hydrogen, oxygen, and carbon, and their combinations in water and carbonic acid, and demonstrated that they make it possible for living things to be formed and exist. An insightful social philosopher as well as physical chemist, Dr. Henderson, professor of biological chemistry at HMS, wrote that "the practice, teaching, and science of medicine have never been isolated from the other affairs of men but have modified them and been modified by them." He conceived and helped establish the Fatigue Laboratory at the Harvard Business School in 1926, where it was discovered that the state of "fatigue" was not dependent upon a toxin, but was associated with a number of different physiological states, in all of which the equilibrium of the body had broken down. The Silliman Lectures that he delivered at Yale in 1927 were published as *Blood: A Study in General Physiology*.

Although there was no doubting Henderson's love of scientific inquiry, he many times played the devil's advocate and warned that medicine should stay visibly away from the temptations of science. Indeed, he saw a compelling alliance between medicine and sociology. Henderson was an original thinker who liberally dispensed epigrams for all varieties of persons and things, and who earned his reputation as a wag. His comment that any random patient meeting with any random doctor has a fifty percent

chance of profiting from the encounter is not one of his more tart, but it is still admiringly quoted.

**Walter B. Cannon '00 (1871-1945).** Under Dr. Cannon's inspirational leadership, as the George Higginson Professor of Physiology from 1906 to 1942, the department of physiology at Harvard Medical School achieved intellectual greatness. Best known for his studies of the autonomic nervous system, he coined the term "homeostasis," which describes the tendency of all organisms to maintain a steady state, or fixed internal environment, when confronting a changed or hostile external environment. This was a cap-sulation of Claude Bernard's famous aphorism that "the stability of the internal environment is the condition of a free and independent life." Walter Cannon saw the philosophical profundity that lay in the concept of homeostasis as the basis upon which manmade as well as natural systems



thrived. He was also an innovative educator. While an undergraduate at Harvard College he came in contact with the case method of teaching law, and when he joined the Medical School faculty he received President Eliot's blessing to apply the case method to the teaching of medicine. Cannon's research was prodigious and started while he was a medical student — he was the first to use opaque material for gastrointestinal x-ray studies. Well into his seventies and still questioning after secrets of human functioning, he contributed to the knowledge of the electrophysiology of the brain.



medicine. The time must have been ripe, for faculty and student interest since has generated the above-named societies. David Freiman, M.D., Mallinckrodt Professor of Pathology and former chairman of the curriculum committee, headed the ad hoc committee that worked out the blueprints: small groups, which would be headed by a permanent master, with a ratio of some ten faculty (chosen by the master) to thirty to fifty students. They would be completely voluntary and accommodate all students wishing to join.

Dean Tosteson proposed that at the outset, one or two societies be formed, depending upon the response. Letters sent to the second, third and fourth year classes before the start of the 1978 academic year yielded approximately 130 interested replies. The most equitable way to choose members, it was decided, was by lot: each society would be composed of ten third year, ten fourth and fifteen second year students, with fifteen places reserved for the incoming first year class. The Class of 1982 jumped on the bandwagon too — eighty strong, which necessitated the formation of a third society in short order.

The first two societies, named after Walter B. Cannon and Francis W. Peabody, commenced their activities in the fall of 1978, with the Lawrence B. Henderson Society following suit in early 1979. Two of the ad hoc committee members accepted the Cannon and Peabody masterships: Clifford A. Barger '43A, Robert Henry Pfeiffer Professor of Physiology and Leon Eisenberg, M.D., Maude and Lillian Presley Professor of Psychiatry, respectively. Norman Geschwind '51, James Jackson Professor of Neurology, is the master of the Henderson Society.

The dental students elected to form their own academic societies, similar in organization and purpose to those at the Medical School. Theirs are named in honor of distinguished HSDM alumni and faculty, David Weisberger and G. Earl Thompson.

While Dr. Barger's choice of the Cannon Society reflects the fact that he is writing a biography of this distinguished physiological kin, it does not set a precedent that societies and their masters must share the same discipline. In fact, stated Dr. Freiman, whether the societies would have a

(continued on p. 4)



**Francis W. Peabody '07 (1881-1927).** The first director of the Thorndike Memorial Laboratories at Boston City Hospital from 1922 to 1927, Dr. Peabody firmly believed that researchers should serve as clinicians on the hospital wards; this concept became the underpinning of the integration of medical schools and teaching

hospitals. As a researcher, Dr. Peabody made important contributions to the clinical aspects of the vital capacity of the lungs and the metabolism of respiration. His investigations on the pathology of the bone marrow in pernicious anemia opened the way for the research carried on by his successors at the Thorndike — George Minot '12, who found a treatment for pernicious anemia, and William B. Castle '21, Francis Weld Peabody Professor of Medicine, who discovered why patients with the disease were unable to absorb vitamin B<sub>12</sub>. Peabody's essays on patient care anticipated current concerns about the doctor-patient relationship that have arisen from the growth of medical technology and health care bureaucracy. His views on medical education held that physicians should possess humanitarian empathy in equal proportion to scientific prowess. Generations of HMS students have dedicated themselves to emulate Peabody's philosophy: "The treatment of a disease must be completely impersonal; the treatment of a person must be completely personal."

**Richard C. Cabot '92 (1868-1939).** Dr. Cabot's name is familiar to all who read the *New England Journal of Medicine* as the founder of the weekly clinicopathological conferences at the Massachusetts General Hospital that now appear under "Case Records of the Massachusetts General Hospital." Chief of medicine there from 1912 until 1921 and professor of clinical medicine from 1918 to 1933, he pioneered in the field of medical social work. Unrestricted immigration in the early 1900s had helped create a patient population whose "illnesses" — brought about in large measure by unsanitary living and unhealthy working conditions — were not conducive to conventional medical therapy. Realizing that patient education in proper nutrition, hygiene and related areas would be more efficacious, Dr. Cabot, in collaboration with James Jackson Putnam and Ida B. Cannon, one of the first social workers, established the department of social services at the MGH in 1906. In addition to his esteemed clinical abilities and the numerous textbooks on physical diagnosis and heart disease to his credit, Dr. Cabot was a prolific writer on the



subjects of psychotherapy, ethics and religion. A Boston Brahmin, he spoke out in favor of such politically and medically radical concepts as prepaid medical care. Dr. Cabot became the first appointed professor of social ethics at Harvard College from 1920 to 1932.

theme prompted some disagreement initially. It was resolved that the first three should be allowed "to evolve rather than to have a structure superimposed on them." However, the Richard C. Cabot Society, which will meet starting in the fall, will experiment with the theme of primary care; its master is John D. Stoeckle '47, professor of medicine.

The rate of growth of academic societies may be influenced by fluctuations in attendance during this past year. The preference is for small groups, but since only one-half to two-thirds of the membership attended the various sessions, the enrollment is being increased to seventy students and twenty faculty per society. With the renovations that are underway, Vanderbilt Hall should prove more hospitable than the Countway for holding the monthly dinner meetings.

Though the ad hoc committee has finished its work, an Intersociety Council composed of the masters, Dean Federman and Dr. Freiman, will be shaping the direction that the societies now take, as well as considering the formation of new ones and approving their names. The council also will discuss matters bearing on the program as a whole, for example, its interrelation with the administration, the faculty, and the general student body.

The development of the Cabot Society, with its more structured focus on family practice, will be watched carefully and an attempt made to gauge its impact upon student career choices. Dean Tosteson has said that he would like these societies to function in a manner analogous to the college system at Oxford, where students join upon matriculation. The possibility exists, according to Dr. Freiman, that in the future they may become more

closely tied to the advisory system, and even reinforce some advisory functions, though for the present the two will remain independent.

This past year, with free reign given in regard to format and topics discussed, a wide range of each was explored. All first meetings were organizational with the master presenting a biographical sketch on the person for whom the society was named; program committees were selected to determine future discussion topics. One firm decision ran through their choices: that the subjects be of broad interest and outside the regular curriculum. Topics have ranged from "Voodoo Death and Mind-Body Relations" (Cannon) to discussions on medical education (Peabody) and lying (Henderson).

At one meeting of the Cannon Society, the government's swine flu immunization program of 1977 was examined by invited speaker Harvey V. Fineberg '71, assistant professor of health service administration at the School of Public Health, to determine if alternative measures could have been taken. Dr. Fineberg affirmed that there had been reasonable alternatives, such as stockpiling vaccines. Susan M. Allan, J.D. '81 reported on the implications of the government's forced acceptance of liability for the immunization program after insurance companies refused to insure the pharmaceutical manufacturers.

The Peabody's meetings took a less formal approach. At one session, two students gave brief presentations on the ways in which technology was affecting medical education and the influence of non-M.D. health care providers on the profession. When the time for discussion came, the membership split into smaller groups to debate on related subjects.

If the academic societies productively open up channels for student-faculty communication, they will have more than justified their creation. During this year they have covered much ground, addressing, in the words of Dr. Freiman, "ethical, social, educational, and career issues for which there is too little time in the regular curriculum, but which are of major concern to the developing physician."

## **Parker Professorship: a family tribute**

Establishing a professorship not only recognizes the efforts and concerns of a lifetime but provides a tangible way to perpetuate those interests. So it will be with the Parker B. Francis Professorship in Pulmonary Medicine, which honors Parker B. Francis, Sr., and his son, Parker B. Francis III.

The gift, from the Parker B. Francis Foundations, was presented recently to the Medical School by John B. Francis, a member of the Overseers' Visiting Committee, in memory of his father and brother. Both had been involved for many years in the field of respiratory therapy. In 1913 Francis Sr., a chemist, helped found the Puritan-Bennett Corporation of Kansas City, Missouri, now a world leader in the manufacture and marketing of respiratory therapy equipment, and the largest producer of nitrous oxide. His son was an executive with the company for many years and its president from 1970 until his death in 1973.

When John B. Francis, chairman of the board of Puritan-Bennett and chairman of the Francis, Sr. Foundation, made the presentation, he spoke of his father's and brother's efforts to

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# **FEAST AT HARVARD'S TABLE**

*Ivy* dinner: monday, October 22, 1979 at the Art Institute of Chicago  
(American College of Surgeons' Clinical Congress)

*Ivy* reception: sunday, November 4, 1979 at the Washington Hilton  
(Associate of American Medical Colleges)

For details, please write the Alumni Office, Harvard Medical School  
25 Shattuck St., Boston, Massachusetts 02115



promote advances in the field of respiratory therapy equipment and supplies. "The professorship at the Medical School joins their names to some of the goals of their lives' work."

The professorship will be located at the Peter Bent Brigham Hospital, the respiratory division of which was started with support from the Parker B. Francis, Sr. Foundation. In accepting the gift, Dean Tosteson noted that in the past years the respiratory division has "attracted a group of very talented physicians whose scientific investigations and work with patients and students have been outstanding. The new gift from the Francis Foundations will further strengthen the division, and thus the hospital and the Medical School."

Work already in progress at the unit has made significant contributions to an understanding of acute asthma and exercise-induced asthma; and new treatments for breathing cessation during sleep have resulted from research on the causes of sleep apnea. Current research includes obstructive airway diseases such as asthma and bronchitis and the uses of increased airway pressure in the treatment of respiratory failure.

The search for the first Parker B. Francis Professor will begin shortly.

## How inclined alumni are to versify

*May always brings an unprecedented degree of mail to the alumni office – ballots for Alumni Council elections, replies to reunion outings and scientific symposia, and checks for same. It is not unusual to receive unsigned ballots (which, alas, are not counted) or even unsigned checks, but the morning of May 7th, a blank check arrived, with 32 single bills enclosed. The check, however, was readily identified, being imprinted with the name and address of the account holder. The alumni office promptly wrote the forgetful fellow, telling him that if he was remitting payment for the scientific symposia for himself alone he was \$12 to the good. If you are planning on two people you're \$8 behind."*

*The episode provoked Enterpe, muse of lyric poetry, and in the following week's mail we received an explanation:*

The household money vanished  
we did not know where.  
It seemed to have dissolved  
into very thin air.

Father said the money was  
left  
in a new envelope to avoid loss  
and theft.

Little did he know that the  
letter was mailed  
by a kind soul who thought  
his memory had failed.

Thank God the mystery has  
been solved at last!  
Now we can hide money  
like we did in the past.

Sorry that the meeting  
I cannot make.  
Please return the \$32.00  
for the household's sake.

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## Pediatric neuropsychology program at CHMC

The first major formal training program in pediatric neuropsychology will be starting up this September at Children's Hospital Medical Center. The year-long program for graduate students, under the direction of Natalie Sollee, Ph.D., chief of the neuropsychology assessment unit, and lecturer in psychiatry at HMS, will develop professional skills in diagnosing and counseling neurologically impaired children.

The clinical neuropsychology unit at CHMC is itself relatively new, having been established three and a half years ago with the support of the psychology and neurology departments to meet the growing demand for more sophisticated evaluations of children with known or suspected central nervous system dysfunction. Dr. Sollee says her unit's identity differs from the orientation of the traditional clinical

psychologist in that it "tries to look at what is known about brain function and anatomy developmentally — and the key word is 'developmentally.' At this time, Children's is one of the few places where this approach is being used."

In the last decade, significant advances in understanding brain function have been made, and more refined and informative tests developed to identify the elusive and complex problems caused by neurological dysfunction. The trainees at Children's will administer batteries of cognitive assessment tests, sometimes supplemented by projective techniques, to differentiate between organic and functional causes of a child's disorder. In addition, they will evaluate aspects of social and emotional adjustment.

"About half the children we see

have diagnoses of neurological impairment, such as seizures, cerebral palsy, muscular dystrophy, and autism," Dr. Sollee explained. "The other half are so called 'learning disabled.' Of the total group, about seventy-five percent have emotional problems which we think are related to their cognitive difficulties." Dr. Sollee notes that it is important to consider "the whole child, so that tests of intellectual and cognitive functions designed to identify brain-behavior relations are interpreted against a background of the child's educational, social, and family environments."

The training program, which is open to postdoctoral graduates from programs in neuropsychology as well as those in clinical, developmental, experimental, counseling and educational psychology, is an effort to attract individuals from a number of subdisciplines into an expanding corps of people with expertise in this relatively new field.

## Fellowships for five in Class of 1980

Five members of the Class of 1980 have been awarded fellowships and are or will shortly be peripatetic in locales as diverse as England and Lambrarene, Gabon.

Sam Stanley, Mark Kerouac, Carolyn Douglas and Lynn McKinley, winners of Albert Schweitzer Fellowships, have the honor of serving at the Albert Schweitzer Hospital. The women have the additional distinction of being the first to serve in such a capacity. Fellowships last three months; Sam Stanley and Mark Kerouac left for Gabon on April 25 and Carolyn Douglas and Lynn McKinley followed them early in August.

In Gabon, all will be directly involved with patient care. One of the prerequisites for consideration was completion of both medical and surgical clerkships. Fluency in French and an essay describing the reasons for interest in the program were other criteria. Dr. Dieter Koch-Weser, As-

sociate Dean for International Programs, is chairman of the fellowship committee.

Sam Stanley explained that he expected the experience to be "a unique opportunity to improve my knowledge of tropical medicine and also a firsthand way of evaluating certain public health issues. For example, how important is a semi-modern hospital in a country where most of the real health problems are exogenous, and what is the most appropriate allocation of resources under those conditions?"

Harvard's ties with the Schweitzer Hospital began with Paul Dudley White '11, who made three visits there in the 1960s, and who suggested to Dr. Schweitzer that some of the money being spent on medical care might be better utilized in public health measures, such as cleaning up the swamps.

While his classmates are in the tropics, Mark Goldberg, winner of a

Sheldon Travelling Fellowship for the year 1979-1980, will be investigating two types of health care — that of England and rural sections of the United States. He plans to spend six or seven months in England, participating in as well as formally studying their health care delivery system and will undertake a clerkship in internal medicine for three months to focus on his special interest of social and community medicine. He will also enroll at Edinburgh University for ten weeks, taking courses in community medicine and general practice.

Upon his return, he will "spend at least four months in a rural work setting — perhaps in New Mexico or California — in order to understand the role of the rural physician's work in health care delivery." After this apprenticeship, Mr. Goldberg will visit colleges and schools that have innovative educational programs to study regional differences with respect to structure and content of premedical and medical education.

## "Strange Sleep" opens Leaders' series

The Boston-based public television documentary, "Strange Sleep," a dramatization of the discovery and early experimentation with ether anesthesia, headlines this year's Leaders in American Medicine series. Aired in 1974 as part of WGBH's series, "Nova," the film features several Harvardians in historical portrayals. Oliver Cope '28, professor of surgery, emeritus, performs as the Olympian John C. Warren; Susanne Learmonth '52, assistant professor of surgery at Dartmouth Medical School — who at the time was instructor in anesthesia at the MGH — plays the anesthesiologist; the intrepid dentist Horace Wells is acted by Edward Seldin, D.M.D. '68, M.D. '74, assistant professor of oral surgery at the MGH; and William Wood '66, assistant professor of surgery, has the role of Dr. Hall. The other medical cast members include Terrence Hayes, D.M.D. (William Morton); Jerome Lettvin, M.D., Ph.D. ("Professor" Colton); Martin Cameron, M.D. (Dr. J. V. Simpson); John Griffin, M.D. (country doctor); and Stuart George, M.D. (Dr. William Halsted).



From "The Conditioned Reflex."

"Strange Sleep" is not the only televised film to be shown at this year's Leaders' series. The second symposium, on November 14, 1979, is on C.J. Jung and includes an interview that he granted to the BBC shortly before his death entitled, "Face to Face." For the fourth program on March 12, 1980, the film "The Conditioned Reflex," which explores the scientific work that Pavlov conducted in Leninograd and contains rare documentary footage, will be screened. The film was produced by USSR Central Television and the Soviet Academy of Science.

In addition, programs will be devoted to Stanley L. Robbins, M.D., former chairman of the pathology department at Boston University School of Medicine and Sir William Osler, first professor of medicine at Johns Hopkins School of Medicine from 1889-1905.

The exact programs are as follows:

- **The History of Ether Anesthesia.** Wednesday, October 10, 1979. Discusants: Leroy D. Vandam, M.D., professor of anesthesia, Harvard Medical School; and J. Francis Gladstone, writer, director and producer of the film.
- **Carl Gustav Jung, M.D. (1875-**



1961). Wednesday, November 14, 1979. Discussants: Margaret C.L. Gildea, M.D., professor of clinical psychiatry, emerita, Washington University School of Medicine; William McGuire, M.A., editor of *Freud/Jung Letters*, executive editor of *Collected Works of C.G. Jung*, and associate editor, Princeton University Press; and Robert Bosnak, analytical psychologist, Institute for Analytical Psychology.

□ **Stanley L. Robbins, M.D.**

Wednesday, February 13, 1980.

Discussants: John I. Sandson, M.D., Dean and professor of medicine, Boston University School of Medicine; and Stanley L. Robbins, M.D., Associate Dean for Resources and professor of pathology, Boston University School of Medicine. The videotape interview with Stanley Robbins by George E. Gifford, Jr. was produced by the educational media support center, Boston University School of Medicine.

□ **Ivan Petrovitch Pavlov, M.D.**

(1849-1936). Wednesday, March 12, 1980. Discussants: Peter B. Dews, M.B., Ch.B., Ph.D., Stanley Cobb Professor of Psychiatry and Psychobiology, Harvard Medical School; John R. Pappenheimer, M.D., George Higginson Professor of Physiology, Harvard Medical School; and B.F. Skinner, Ph.D., Sc.D., Edgar Pierce Professor of Psychology, Emeritus, Harvard University.

□ **Sir William Osler, M.D. (1849-1919).** Tuesday, April 29, 1980. Slide presentation by Charles G. Roland, M.D., Jason A. Hannah Professor of the History of Medicine and Related Sciences, McMaster University, Hamilton, Ontario, Canada.

Discussants: Daniel C. Tosteson '49, Dean and Caroline Shields Walker Professor of Physiology, Harvard Medical School; and William B. Bean, M.D., Sir William Osler Professor of Medicine and Kemperer Professor and Director, Institute for Medical Humanities, University of Texas Medical Branch at Galveston.

All programs begin at 4:30 pm at the Countway Library auditorium, preceded by a half hour for refreshments. The Leaders in American Medicine series is sponsored by Boston University School of Medicine, Benjamin Waterhouse Medical History Society, Boston Medical Library,

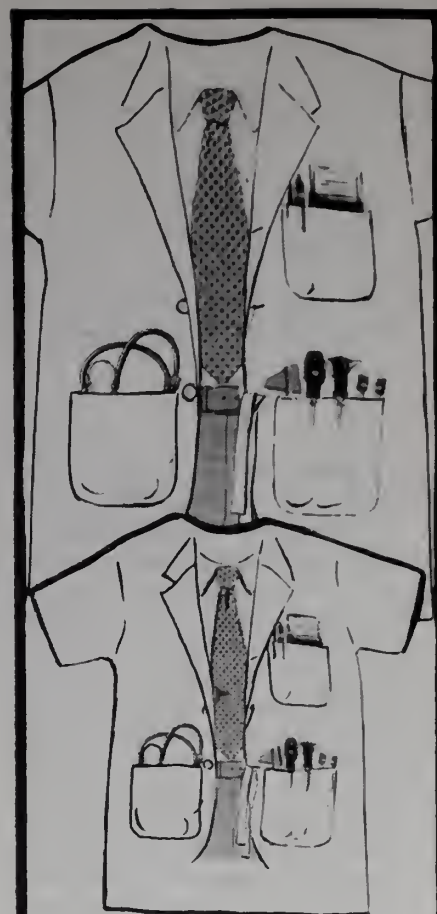
Brown University Program in Medicine, Harvard Medical School, and Tufts University School of Medicine and is under the chairmanship of George E. Gifford, Jr., M.D. The series is made possible by a grant from the Josiah Macy, Jr. Foundation, and meets the criteria for one and a half hours for each session in Category I certification by BUSM.

## A million dollar day

As Skylab came tumbling down, the Harvard Medical School went up, that is, the fortunes of HMS climbed to new heights. On July 12, the Alumni Fund finished totting up contributions for fiscal 1979, and surpassed the million dollar mark. \$1,010,000 in "cold cash," to be exact, was the figure announced by the fund's guiding light, Carl W. Walter '32. A small gathering of friends jubilantly toasted this crowning achievement in current use and endowment funds and Dr. Walter's steadfast leadership over the past eight years. That million dollars (which at last count on July 27 had inched up to \$1,072,000) can be divided up into some 4,252 gifts from loyal HMS supporters.

Related statistics were also worth toasting: the Medical School's fund raising capabilities have nearly quintupled since 1969, when \$231,000 was raised; over ninety per cent of HMS alumni/ae have contributed at least once since 1971; and the annual participation rate has hovered at the fifty-six per cent mark for several years now. This contrasts with Harvard College's enviable fund-raising record that is based, however, on an average of thirty-five per cent participation.

Naturally, a few stories were exchanged about Carl Walter's fiduciary prowess. Richard Olendski, associate dean for financial affairs, confided that he had suggested repeatedly the idea of targeting, but to no avail. Carl Walter had consistently refused, saying only that he was going to raise a million dollars and then retire. But, as one of the cele-brants noted, because of the inflationary factor, the partnership of Carl Walter and the alumni/ae will be in full swing for some time to come. As they say, the first million (inflation or no) is always the most difficult.



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## Mortimer Litt, M.D. Associate Dean for Educational Programs

**"T**he basic idea behind an office of this sort is that one should facilitate the educational process by minimizing the chores that the faculty and students must engage in. We are an operating arm of the curriculum: we expedite, manage, and plan." Mortimer Litt, M.D., recently appointed Associate Dean for Educational Programs at the Medical School, is outlining the scope of his position. Changes have taken place in the six years he has held it and to encompass them, the Office of Teaching Resources has been renamed the Office for Educational Programs.

Dr. Litt this year marked his twenty-fifth anniversary of working in the Quadrangle. An associate professor of microbiology and molecular genetics, he still finds the time to teach in a course in infectious disease.

When he first began, he recalled, "a faculty member had to visit a dozen places to coordinate a course — particularly interdepartmental ones such as pathophysiology — that were based in the hospitals and were without the obvious resources that would be available to a Quadrangle department. Students also had to run around. The concept of this office was to give them one place where all the resources that were needed could be obtained, and to avoid duplication of effort." Dr. Litt's office now has charge of the preparation and distribution of course syllabi and catalogues, the scheduling of classrooms and all common space, audiovisual functions, and publishing. He is also involved in the process of "shepherding courses from their initial proposal to publishing them in the *Course Catalogue*." To these ends, Litt works closely with Dean Adelstein and the Office of Academic Programs, and finds the relationship "a critical one.



Dr. Adelstein heads the group that includes Eleanor Shore ('55) and myself. She is responsible for faculty, I for curriculum support, and he for all of it."

Students, upon entering the Medical School, rapidly become familiar with the office, which occupies renovated space adjacent to Amphitheater E. It is where lockers and shuttle bus passes are issued and where the course handouts that accompany lectures can be obtained. Students troop up the

stairs in September to rent microscopes and to borrow microscope slide collections. Litt's office also manages and provides material for the software library and the self-teaching facilities, both of which are housed in the Countway Library; selected lectures are taped so that students can replay them whenever they wish. Ensuring that pertinent reading matter is kept on reserve in the Countway and monitoring the availability of textbooks at the



## The normal fare of Litt's department includes acquiring, assigning, issuing and retrieving educative materials.

Harvard Coop are other facets of the enterprise.

One example of the demands now placed upon this office can be seen through what has happened in the Introduction to Clinical Medicine, a staple in the lives of all second year students. Beginning this fall, the Office for Educational Programs will coordinate and support resources for the ICM, the most important and scarce of which is patients. Students must gain experience in history-taking and physical examination, and patients in teaching hospitals are repeatedly subjected to both. Understandably, many patients become anxious and annoyed, while students fear that their probing is bothersome and contributes little to patient care. According to Litt, the situation has been ameliorated by the hiring of surrogate patients who do not mind being partially examined, thereby allowing students to feel comfortable in taking the time to be thorough.

The production of printed materials and audiovisual aids are two areas that have been affected by new technology, which the Office for Educational Programs has had a hand in introducing to the HMS community. Margaret Whitchurch, manager of print production and publications, offers assistance in matters of style, typeface, layout, paper, and external vendors in regard to numerous publications. These include yearly "regulars" such as the faculty and staff directory, the *Course Catalogue*, and the orientation manual for entering students, as well as the student newspaper, *The Present Illness*, and course handouts.

"The bulk of printed course materials is stable," remarks Litt, "and we now have ways to expedite the editing

process. We are much more activist about it than in the past." The Information Service Center — located in the basement of Building A — is an important part of the effort to streamline the production of much of the School's published material. Computer assisted typing — otherwise known as word processing — is now being used routinely. It relieves much of the drudgery of preparing manuscripts, particularly those that remain substantially the same from year to year, since once material is entered into the system, making changes and additions becomes trivial. This office is under the auspices of Mitchell Adams and the Office for Finance and Business, and its interaction with Litt's office is evidence of improved administrative coordination.

The use of audiovisual technology is having an increasing impact on teaching. The Medical School shares a closed circuit television system with the schools of public health and dental medicine, and the Peter Bent Brigham. Research seminars comprise the bulk of the broadcasts — one in biochemistry is sent weekly to William James Hall at the College, to MIT, to the MGH, to Mt. Auburn, to the University of Massachusetts at Columbia Point, and to Tufts University. Litt thinks that this capability will be used more and more, especially as travel between institutions and the parking situation become more onerous.

While such an innovation conveniently can extend the physical reach of information, it cannot solve problems of inadequate space at the home front and Litt worries that "we have long outgrown our facilities." As his office is responsible for scheduling assignments for classrooms and conference rooms, he knows that space is a com-

modity in short supply. "It is becoming difficult to satisfy the needs of administration, teaching and research. The question sometimes becomes, 'How can we efficiently make do?'"

No doubt he has a detailed analysis of all of HMS's likely nooks and crannies through his role as chairman of the Medical Area Committee on Environmental Health and Safety. In addition to inspecting and monitoring facilities, Litt assists in developing laboratory safety policies and educating personnel to assure compliance with intra- and extramural codes.

Part of the program at the Medical School includes regular inspection of all areas by experts, and every laboratory floor in the Quadrangle has two people assigned to safety. Questions about hazardous materials are regularly examined by the committee.

"How much flammable material can be stored? Where? We work out delivery schedules with suppliers to minimize the amount of dangerous substances that are on hand, so that if something does go wrong, there won't be a large amount of material at one site. Fire drills, electrical wiring, and ventilation all must be considered, and the proper safety methods enforced. All this expertise is shared with the affiliated hospitals in meetings of the Hospital Safety Subcommittee."

In some way, the work of the Office for Educational Programs touches every laboratory and office in the Medical School. On an ordinary day, students, faculty, and innumerable others can be seen in Dr. Litt's department. It's traffic that he accepts with equanimity, normal fare for an office that "acquires, assigns, issues, and retrieves" materials that form a vital link in the educational process.

NANCY V. KOUGEAS



Dean Tosteson congratulates Luis LaLuz (holding his son) and Joseph Pober on their residency positions.

## The Class of 1979: on to the hospital

The waiting was over for the Class of 1979 on March 14 — Match Day, when internship and residency appointments obtained through the National Resident Matching Program become known. The occasion signals a milestone in the transition of medical students to fledgling doctors. At a reception in the Benjamin Waterhouse Room Dean Tosteson congratulated the class on its collective achievement: "This School has the reputation for providing the best in higher education in medicine. That reputation rests on

the service rendered by its graduates. You are now in this tradition and I know you will carry it on."

The Class of 1979 fared well: all 142 students seeking to be matched were, with over half receiving their first choices. Approximately three quarters were accepted by either their first, second, or third choices, while ten students chose to match outside of the program. "Each year we turn out the best class that has ever graduated from Harvard Medical School, and this year is no exception," boasted Curtis

Prout '41, chairman of the Internship Advisory Committee. Dr. Prout counsels and advises students and prepares letters of recommendation for each, based on faculty comments as well as his own observations.

Though the excitement peaks on Match Day, statistics continue to fluctuate as applications are made to programs for training after the first post-graduate year. To date, applications have been made to residencies in the following specialties: four to radiology programs; three to ophthalmology; two to psychiatry (in addition to the four students already noted on the residency list); two to dermatology; and one each to anesthesia, otolaryngology (surgery), and neurosurgery. Two students have applied for Army residencies and one to a Navy program.

## Internships & Residencies 1979

Addante, Rocco R.

Beth Israel Hospital

*Surgery*

Adzick, Nick S., 3d

Massachusetts General Hospital

*Surgery*

Alpert, Susan D.

Stanford University Hospital

*Pediatrics*

Andrews, Debra

Mount Zion Hospital

San Francisco, *Pediatrics*

Angiolillo, Dea F.

University of California Hospitals

San Francisco, *Medicine/Primary Care*

Atwood, Kimball C., 4th

Beth Israel Hospital

*Internal Medicine*

Aurigemma, Gerard P.

Moffitt-San Francisco General Hospital

*Internal Medicine*

Barnett, Marguerite P.

Tripler Army Medical Center

Honolulu, *Surgery*

Bauman, Andrew J.

Dartmouth/Hitchcock Center

Hanover, *Internal Medicine*

Bayer, William H.

Highland Hospital

Rochester, *Family Practice*

Bennet, Nancy E.

New England Medical Center

Boston, *Internal Medicine*

Billings, Paul R.

University of Washington Affiliated Hospitals

Seattle, *Medicine/Primary Care*

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**Nine minus one.** In the line-up of deans that appears on page 7 of the March/April HMAB, we inadvertently listed eight names with nine faces. The correct order of deans is as follows: Meadow, Olsson, Eisenberg, Ryan, Tosteson, Adelstein, Spellman, Adams, and Shore.



Biro, Frank M., Jr.  
University of Rochester Associated  
Programs, *Internal Medicine*  
Bloomer, Sarah K.  
Children's Center/University Hospital  
Seattle, *Pediatrics*  
Bradley, Arlene B.  
Peter Bent Brigham Hospital  
*Internal Medicine*  
Brenkus, Lawrence M.  
Montefiore Hospital & Medical Center  
Bronx, *Pediatrics/Primary Care*  
Brenner, Leona  
NYU-Bellevue Hospital  
*Internal Medicine*  
Breyer, Matthew D.  
Michael Reese Hospital  
Chicago, *Internal Medicine*  
Brodie, Howard R.  
Mount Zion Hospital  
San Francisco, *Internal Medicine*  
Burke, Patricia Y.  
Children's Hospital Medical Center  
*Pediatrics*  
Butterly, Lynn F.  
Massachusetts General Hospital  
*Internal Medicine*  
Campbell, Thomas L.  
Highland Hospital  
Rochester, *Family Practice*  
Casscells, S. Ward  
Beth Israel Hospital  
*Internal Medicine*  
Chan, Chun-Wai  
Boston VA Hospital (Tufts Program)  
*Internal Medicine*  
Chin, John K.  
Moffitt-San Francisco General Hospital  
*Surgery*  
Chuong, Robert  
Massachusetts General Hospital  
*Oral Surgery*  
Churchwell, Andre L.  
Grady Memorial Hospital  
Atlanta, *Internal Medicine*  
Cochran, David  
University of California Hospitals  
San Francisco, *Medicine/Primary Care*  
Crues, John V., 3d  
LAC/USC Medical Center  
Los Angeles, *Internal Medicine*  
Curnutte, John T.  
Massachusetts General Hospital  
*Pediatrics*  
Davidson, Nancy E.  
Hospital of the University of Pennsylvania  
Philadelphia, *Internal Medicine*  
de Cholnoky, Corinne E.  
George Washington University Hospital  
*Obstetrics/Gynecology*  
Deckelbaum, Lawrence I.  
Peter Bent Brigham Hospital  
*Internal Medicine*  
De Stefano, Paul M., Jr.  
Beth Israel Hospital  
*Internal Medicine*  
Dewey, Larry V.  
Yale/New Haven Hospital  
*Psychiatry*  
Diette, Kevin M.  
Beth Israel Hospital  
*Internal Medicine*  
Distelhorst, James S.  
Providence Hospital Medical Center  
Seattle, *Family Practice*  
Dixon, Marvin L.  
Duke University Medical Center  
Durham, *Pediatrics*  
Doyle, Christopher J.  
Peter Bent Brigham Hospital  
*Surgery*  
Everitt, Daniel E.  
Massachusetts General Hospital  
*Medicine/Primary Care*  
Fallor, Douglas V.  
Moffitt-San Francisco General Hospital  
*Internal Medicine*  
Fintel, Dan J.  
Mount Sinai Hospital  
New York, *Internal Medicine*  
Flicker, Wayne M.  
Huntington Memorial Hospital  
Pasadena, *Internal Medicine*  
Galbo, Claudia E.  
National Naval Medical Center  
Bethesda, *Radiology*  
Garcia, Umberto I.  
University of California Hospitals (Irvine)  
Orange, *Family Practice*  
Garland, James L.  
Peter Bent Brigham Hospital  
*Internal Medicine*  
George, Paula B.  
Children's Hospital Medical Center  
*Pediatrics*  
Gonzalez, Melvin A.  
Hospital of the University of Pennsylvania  
Philadelphia, *Internal Medicine*  
Gordon, David  
University of Massachusetts Coordinated  
Programs  
Worcester, *Internal Medicine*  
Gore, Ronald G.  
Massachusetts General Hospital  
*Pediatrics*  
Gorin, Batya  
Montefiore Hospital & Medical Center  
Bronx, *Internal Medicine*  
Greenspan, Susan L.  
Beth Israel Hospital  
*Internal Medicine*  
Greenstein, Stuart M.  
NYU Medical Center  
*Surgery*  
Greer, Gary W.  
University of California Hospitals  
San Diego, *Surgery*  
Haas, Susan  
Boston Hospital for Women  
*Obstetrics/Gynecology*  
Haynor, David R.  
University of Washington Affiliated Hospitals  
Seattle, *Surgery*  
Hendren, William G.  
Massachusetts General Hospital  
*Surgery*  
Hensley, William M.  
Massachusetts General Hospital  
*Internal Medicine*  
Higginbotham, Eve J.  
Pacific Medical Center (Presbyterian  
Hospital)  
San Francisco, *Internal Medicine*  
Hirsh, Michael P.  
Presbyterian Hospital  
New York, *Surgery*  
Hom, Gerald A.  
University of California Hospitals  
San Diego, *Internal Medicine*  
Hoyt, Mary B.  
Boston Hospital for Women  
*Obstetrics/Gynecology*  
Hughes, Robert A.  
Massachusetts General Hospital  
*Medicine/Primary Care*  
Ingard, John U.  
Mount Auburn Hospital  
*Medicine/Primary Care*  
Jacoby, Steven S.  
Massachusetts General Hospital  
*Internal Medicine*  
Jaski, Brian E.  
University of Chicago Clinics & Hospitals  
*Internal Medicine*  
Jonas, Jeffrey M.  
McLean Hospital  
*Psychiatry*  
Jones, Gary J.  
Children's Center/University Hospital  
Seattle, *Pediatrics*  
Katz, Rebecca L.  
LAC/Harbor General Hospital  
Torrance, *Pediatrics*  
Kellogg, Pamela P.  
Michael Reese Hospital  
Chicago, *Psychiatry*  
Kelly, John T.  
Children's Hospital  
San Francisco, *Internal Medicine*  
Kessler, David A.  
Johns Hopkins Hospital  
Baltimore, *Pediatrics*  
Kieval, Shalom J.  
Massachusetts General Hospital  
*Internal Medicine*  
Kincannon, Elizabeth A.  
University of Colorado Affiliated Hospitals  
Denver, *Pediatrics*  
Kipps, Thomas J.  
Stanford University Hospital  
*Internal Medicine*  
Kirkham, Sara E.  
Massachusetts General Hospital  
*Pathology*  
Kirshenbaum, James M.  
Peter Bent Brigham Hospital  
*Internal Medicine*  
Krauss, Marlene R.  
Beth Israel Hospital  
*Internal Medicine*  
Kritzik, Susan G.  
Moffitt-San Francisco General Hospital  
*Medicine/Primary Care*  
Krupkin, Donna J.  
VA/Wadsworth Hospital  
Los Angeles, *Internal Medicine*  
LaLuz, Luis A., Jr.  
University of California Hospitals  
Irvine, *Family Practice*  
Lambiase, Elyse A.  
CWRU/University Hospital  
Cleveland, *Internal Medicine*  
La Muraglia, Glenn M.  
Massachusetts General Hospital  
*Surgery*

Lavizzo-Mourey, Risa J.  
Peter Bent Brigham Hospital  
*Internal Medicine*

Levine, John B.  
Framingham Union Hospital  
Framingham, Massachusetts, *Flexible*

Like, Robert C.  
CWRU/University Hospital  
Cleveland, *Family Practice*

Link, Nan A.  
Moffitt-San Francisco General Hospital  
*Internal Medicine*

Louie, Karen G.  
University of Chicago Hospitals & Clinics  
*Internal Medicine*

Madison, John M.  
Barnes Hospital Group  
St. Louis, *Internal Medicine*

Maziarz, Richard T.  
CWRU/University Hospital  
Cleveland, *Internal Medicine*

Miller, Rudolph H., 3d  
Stanford University Hospital  
*Pediatrics*

Murphy, Alma I.  
Waterbury Hospital  
Waterbury, Connecticut, *Internal Medicine*

Myers, Anne M.  
Peter Bent Brigham Hospital  
*Internal Medicine*

Numata, Tetsuto  
Beth Israel Hospital  
*Surgery*

Oriol, Nancy E.  
Beth Israel Hospital  
*Surgery*

Parmett, Steven R.  
University of Massachusetts Coordinated  
Programs  
Worcester, *Internal Medicine*

Pelikan, Peter D.  
LAC/Harbor General Hospital  
Torrance, *Internal Medicine*

Piccoli, David A.  
Children's Hospital Medical Center  
*Pediatrics*

Pober, Joseph M.  
The New York Hospital  
New York, *Surgery*

Prothrow-Stith, Deborah B.  
Boston City Hospital  
*Internal Medicine*

Rand, Rhonda E.  
Mount Sinai Hospital  
New York, *Internal Medicine*

Reed, Stanley D.  
The New York Hospital  
New York, *Internal Medicine*

Rees-Jones, Robert W.  
Presbyterian Hospital  
New York, *Internal Medicine*

Resnick, Arthur D.  
University of Washington Affiliated Hospitals  
Seattle, *Internal Medicine*

Rigby, William F. C.  
New England Deaconess Hospital  
*Internal Medicine*

Rippe, James M.  
Massachusetts General Hospital  
*Internal Medicine*

Robbins, Mark E.  
Boston City Hospital  
*Internal Medicine*

Robinson, Kenneth S.  
Beth Israel Hospital  
*Internal Medicine*

Rockefeller, Richard G.  
Highland Hospital  
Rochester, *Family Practice*

Rodriguez, Pascual B.  
Montefiore Hospital & Medical Center  
Bronx, *Internal Medicine*

Rogers, Ancel J.  
Cedars-Sinai Medical Center  
Los Angeles, *Surgery*

Rome, Dan H.  
Virginia Mason Hospital  
Seattle, *Flexible*

Rowe, Richard W.  
University of California Affiliated Hospitals  
San Diego, *Pediatrics/Primary Care*

Ruddock, Vilma E.  
Boston Hospital for Women  
*Obstetrics/Gynecology*

Ruff, Lynne H.  
LAC/Harbor General Hospital  
Torrance, *Pediatrics*

Russell, Kenneth J.  
Stanford University Hospital  
*Pediatrics*

Safranek, Louis L.  
Beth Israel Hospital  
*Surgery*

St. Goar, Anne F.  
Massachusetts General Hospital  
*Medicine/Primary Care*

Samoszuk, Michael K., Jr.  
Peter Bent Brigham Hospital  
*Pathology*

Satlin, Andrew  
The New York Hospital  
New York, *Internal Medicine*

Schoenfeld, Mark H.  
Massachusetts General Hospital  
*Internal Medicine*

Schwartz, Vicki A.  
Bronx Municipal Hospital Center  
New York, *Internal Medicine*

Schwartzstein, Richard M.  
Beth Israel Hospital  
*Internal Medicine*

Shields, Anthony F.  
University of Washington Affiliated Hospitals  
Seattle, *Internal Medicine*

Slater, Jay E.  
Presbyterian Hospital  
New York, *Pediatrics*

Sorge, Joseph A.  
Rhode Island Hospital  
Providence, *Surgery*

Spiro, Carolyn S.  
Beth Israel Hospital  
*Internal Medicine*

Stein, Jill E.  
Cambridge Hospital  
*Internal Medicine*

Stein, Judith K.  
Christ Hospital  
Cincinnati, *Internal Medicine*

Steinberg, Earl P.  
Massachusetts General Hospital  
*Medicine/Primary Care*

Sterne, Thomas C.  
Massachusetts General Hospital  
*Medicine/Primary Care*

Sukhatme, Vikas P.  
Massachusetts General Hospital  
*Internal Medicine*

Supple, Edward W.  
Massachusetts General Hospital  
*Internal Medicine*

Svetkey, Laura P.  
Montefiore Hospital & Medical Center  
Bronx, *Internal Medicine*

Swann, Eric S.  
Highland General Hospital  
Oakland, California, *Internal Medicine*

Swerdlow, Barry N.  
Stanford University Hospital  
*Internal Medicine*

Taylor, Henry G.  
Baltimore City Hospitals  
*Medicine/Primary Care*

Tomaselli, MaryBeth  
Peter Bent Brigham Hospital  
*Surgery*

Toomey, Kathleen E.  
University of Washington Affiliated Hospitals  
Seattle, *Family Practice*

Troy, Leo J., Jr.  
Walter Reed Hospital  
*Surgery*

van der Horst, Charles M.  
Montefiore Hospital & Medical Center  
Bronx, *Internal Medicine*

Van Niel, Anthony  
Peter Bent Brigham Hospital  
*Internal Medicine*

Vasconcellos, Carol A.  
University of Massachusetts Coordinated  
Programs  
Worcester, *Internal Medicine*

Vonnegut, Mark  
Massachusetts General Hospital  
*Pediatrics*

Walter, James J.  
Michael Reese Hospital  
Chicago, *Internal Medicine*

Walters, Bradford B.  
Johns Hopkins Hospital  
Baltimore, *Surgery*

Warner, Cheryl K.  
Mount Auburn Hospital  
*Medicine/Primary Care*

Weinberger, Edward  
Children's Center/University Hospital  
Seattle, *Pediatrics*

Willard, Douglas R.  
LAC/Harbor General Hospital  
Torrance, *Internal Medicine*

Witkie, Susan M.  
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Yock, Paul G.  
Moffitt-San Francisco General Hospital  
*Internal Medicine*



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# Alumni Day 1979



Alumni Day, always warmed by the good will and camaraderie of renewed friendships, had the additional fortune this year to take place under the clear skies of the first of June.

Perry J. Culver '41, director of alumni relations, and Daniel D. Federman '53, dean for students and alumni, briefly greeted the 375 returning alumni/ae and 293 spouses, then turned the program over to moderator Thomas F. O'Brien '54 who welcomed his "extended family, the twenty-fifth reunion class. To all of you born too

soon or too late to have been in the Class of '54, I sincerely hope that life has or will bring some offsetting compensation — although I can't imagine what that could be."

Dr. O'Brien detailed an experiment, of which all alumni/ae are part: "The protocol has been to gather together from varied backgrounds an enthusiastic and perceptive group of young people to share an intense four year educational experience. After their years here the students are dispersed to do whatever ingenious thing they can think of to do with their train-

ing. They cure people and reassure others and collect some third party or NIH funding or whatever, all of which are good things.

"Periodically," he continued, "this whole intelligence-gathering apparatus is called back, cohort by cohort, under the guise of reunions, to exchange and synthesize what has been learned about people, about themselves, and about the world. The true purpose of this enormous undertaking then, is to derive a fresher and truer perception than ever before of the physical universe and the human experience in it. This morning we are taking depositions on these issues from witnesses."

The testimony was as diverse as a report of a fledgling flight into the world of small town politics to an anthropological discourse on primitive societies. When all were finished, William R. Christensen '42, the outgoing president, called the eighty-fifth annual business meeting of the Alumni Association into session. The new officers and councillors — elected by 2,344 alumni — were announced: Eben Alexander '39 president-elect, Doris R. Bennett '49 treasurer, and Carter R. Rowe '33 councillor at large. Councillor from the second pentad is Penelope K. Garrison '69 and from the fifth pentad, Anthony P. Monaco '56. The unsuccessful candidates were Marshall deG. Ruffin '36, Phyllis B. Robbins '53, Renee L. Gelman '50, Melinda K.G. Zitin '73, and Victor W. Sidel '57.

After welcoming those newly elected, Dr. Christensen thanked the members whose terms have been completed. Past-president Thomas P. Quigley '33, has been ill for several months and to him Dr. Christensen expressed thanks for his exemplary leadership and wished him, on behalf of the Alumni Association, a continued convalescence. The others who have finished their terms are: Fiorindo A. Simeone '34, treasurer, and concil-



lors Nina Tolhoff-Rubin '68, K. Frank Austen '54, and Grant V. Rodkey '43A. Three original members of the Alumni Survey Committee have completed their five year terms: Paul J. Davis '64, James R. McArthur '56, and Henry W. Vaillant '62.

The new additions to the Alumni Survey Committee are Richard P. Stetson '26, Gertrude E. (June) Murray '54 and Henry W. Vaillant, who has been reappointed for a three year term.

The report on the assets of the Alumni Association was next on the agenda — an event, Dr. Christensen said, that always brings "great joy and gladness. The Alumni Fund is run by a most effective person and he always brings good news. That person is, of course, none other than Carl W. Walter '32."

Herbert J. Goldings, class agent for 1954, gave Dr. Walter a starting point as he presented his class's gift of \$12,246 (which brings their total giving to an impressive \$102,599) and expressed the wish that the class be able



to continue its generosity into the "infinite future."

"Class agents of other reunion classes have been pressing me for the scores of their accomplishments over the past five years," Dr. Walter said and without further delay read the approximate totals. The Classes of 1929 and 1934 topped the list, with amounts of \$80,000 and \$88,000, respectively. The Class of 1939 came in with \$31,000. The Class of 1944 gave

\$55,000, the Class of 1949, \$35,000, and 1959 and 1964 were almost tied with the former contributing \$25,000 and the latter surpassing them by \$2,000. The total — an impressive \$425,000 — was rounded out with the \$12,000 received from the Class of 1969 and \$5,000 from the Class of 1974.

In store was yet another surprise: "The overall performance of the Alumni Association, with 7,055 members, has to date resulted in a total of \$961,000," announced Dr. Walter. "In addition, there is accumulated in the planned giving program a little over a million dollars, so I perceive that by the time the first of July comes around, the Alumni Association will have accumulated upwards of two million dollars for this year's activities." Dr. Walter concluded by asking for a round of applause for the class agents "for their continuing perfection of communication with their classmates."



Catching up: Tom O'Brien collecting some firsthand data for HMS's controlled research study.

Dr. Christensen's term as president has been marked by thoroughness and efficiency and his farewell address was characteristic: a succinct report of the activities — and concerns — of the Alumni Association. During the past year, he said, the Alumni Council has "labored at length to consider a number of ongoing problems of the Harvard Medical School." These included the status



Chewing the Medical School fat: Alumni Association president-elect Gordon A. Donaldson '35 and Richard Warren '34.

of the Alumni Survey Committee and the specific tasks assigned to it, the problems of the junior faculty, the fiscal problems of the School, and the preparations for the 200th anniversary in 1982.

The alumni/ae, Dr. Christensen emphasized, can have a decisive influence on the course of the Medical School. "The effective response literally lies at the points of your pens. Number one is the exercise of your franchise in the election of the Board of Overseers of Harvard College. Carl Walter has repeatedly called our attention to the fact that Harvard University is controlled by its alumni/ae through the election of the Board of Overseers in which you all have a vote. You must show this board that you are concerned with its stewardship in relation to the Medical School.

"The significance of alumni/ae giving has already been called to your attention. The fiscal problems of the Medical School are an area of increasing difficulty. The amount of money which the alumni/ae give now makes up a significant part of the budget. If you are concerned with curriculum content, the quality of student life, the effectiveness of clinical teaching, may I suggest that with your donation, which I urge you to increase, you go on to say, 'I specify that this money be used in the support of clinical teaching, or improvement in the facilities of Vanderbilt Hall.' If you are interested

in controlling the fertility of the white mouse, I suggest you dedicate it to that as well.

"Finally, I plead for your communication. The effectiveness of the Alumni Association, the Alumni Council, Dr. Culver, and Dr. Walter depends upon communication with you. They will do your bidding if you will appraise them of your concerns and what you think are the problems of this organization."

After thanking those who helped during his term, Dr. Christensen turned the badge of office over to Gordon Donaldson '35. Dr. Donaldson gave a brief example of his oratorical style: "It has been said that the alumni body's major function is to provide a sense of continuity to the administration, to the faculty, and to the students of any school. Some have referred to this as 'alumni power,' a term which I dislike. It gives the sense of a boring type of alumni. Others like 'alumni pressure' but I find it rather distasteful because it signifies a subtle aggressiveness. I wonder if 'alumni presence' might be a little more appropriate but that sounds wamzy-pamzy though I think that if one qualifies it by calling it 'positive pressure' we may have a good expression to indicate what we're trying to do."

A little background music, please. A chorus or two of "Gaudeamus igitur" would set the scene most appropriately. There is so much to say and yet there is hesitation. "Twenty-five years" rolls easily off the tongue. But it represents volumes of recollections and reflections.

A year ago, I was invited to be a speaker at the Harvard School of Dental Medicine's Alumni Day program. The topic, aptly enough, was "pain" and we gathered in Building D amphitheatre to hear a psychiatrist, neurophysiologist, and a practitioner. Being the third speaker gave me ample opportunity to indulge my flights of fancy and recall. The amphitheatre suddenly evoked the memory of a cavernous, deeply-tiered room with rows of plywood seats, and steep, creaking stairs that betrayed the presence of a timid classmate sneaking into a seat after the professor had begun the lecture. Newspapers had been quickly folded away and pocket penlights were seen to blink on in the darkened room. Each lecturer had his own unique and memorable style. Otto Kraye always began precisely at 8 am, speaking quietly in a low voice. The room instantly hushed as his lecture progressed and swelled to a climactic coda fifty-five minutes later. We strained to catch his pronunciation of names such as "ouawahbaeen" (ouabaine) and "cocaeen" (cocaine). His accent and his dramatic presence were unforgettable.

There were many others. We were awed by Don Fawcett's embryology lectures, during which he presented schematic drawings of anatomical development and sketched with multi-colored chalk in both hands. Marcus Singer conducted our daily group recitation sessions in neuroanatomy. "Don't worry if you can't remember the Tract of Phillippe and Gambeault!

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*Norman Triege, D.M.D. '54, is chairman of the department of dentistry and oral surgery at Montefiore Hospital and Medical Center and professor of dental surgery at the Albert Einstein College of Medicine. After completing the third and fourth clinical years at Einstein in 1972, he was awarded an M.D. degree. Dr. O'Brien noted that he "has a view of something that sounds terrifying, middle-aged internship."*



# Like Wow, Man A Guide for the Perplexed

by Norman Triege

## Inspirations from the past and intimations of the future

When you put something new up on the shelf, something old usually falls off." So much for the logic of infinity.

Physiology was a high powered course but coupled with biochemistry it really became incomprehensible. Our class pioneered the first conjoined biochem-physiology teaching in a forerunner of the fully integrated basic science curriculum; the final examination taken by freshmen students had to be evaluated and graded by a faculty committee. Eugene Landis and John Pappenheimer stand out. Cliff Barger is remembered for his enthusiasm in relating clinical disease to basic physiology.

We can recall a mild-mannered lecturer named Albert Coons who talked about his lymphocyte cultures. Little did we realize that this was the doorway into the age of immunology, which is still expanding into all areas. John Enders lectured to us about some of his virology studies — growing viruses on human foreskins — confirming the fact that so many gave so little to achieve so much. The direct application of Enders's work became the key to the conquest of poliomyelitis — one of the highpoints in medicine in the past twenty-five years.

Many of us will recall the terror of the polio epidemic of 1955. It caused widespread disease, death and disability and turned at least one floor of the Massachusetts General's White Building into a special rehabilitation unit. This probably contributed in no small way to our understanding of respiratory problems and led to the development of the intensive care unit several years later. I must digress for a brief moment to recognize the recent death of John Knowles at age 52. John was a prime mover in the development of the pulmonary intensive care unit at the MGH.

Another striking recollection is of our pathology course, especially the three intensive weeks given over to parasitology. Who of us can forget the exotic life cycles of the onchocercas, or the peregrinations of the metacercaria of the schistosomes. But perhaps best of all, and still ringing in our ears, is that deathless line delivered in his own inimitable staccato by the dolichocephalic smooth-domed Dr. Donald Augustine who intoned, "The treatment of *Diphylobothrium latum* is oil of chenopodium!" To which we all responded, "Amen, Selah!"

Ultimately we made it out of the first two years, but we were never fully convinced by those all-knowing upperclassmen who kept telling us, "If you were accepted, you'll probably graduate."

Our hospital rotations were varied. We met many notables who were giants in our eyes: Herrman Blumgart, who, in his fatherly way, started us on the path of clinical medicine by advising "...listen to the patient, she's telling you the diagnosis!"

Derek Denny-Brown was already the encyclopedist of neurologic diseases and Maxwell Finland and Louis Weinstein were developing the subspecialty of infectious diseases. The Children's Hospital had many impressive teachers and clinicians such as Charles Janeway, William T. Green in orthopedics, Sidney Farber, and Louis Diamond. Of the group at the MGH, Walter Bauer and Joe Aub evoke both smiles and scowls. We cannot forget the special lecture given by Fuller Albright who used the long bamboo pointer to precisely indicate a particular pathway on the screen only to be drowned out seconds later by the repetitive rapping of the pointer, which transmitted and amplified his tremor.

Allan Butler, a social scientist and compassionate pediatric chief; Stanley Cobb, who was able to meld neurophysiology, psychiatry and metaphysics to enthral impressionable doctors. James C. White and William Sweet in neurosurgery developed the methodology that in future years become the basis for "pain centers," which combined the talents of many special disciplines for the patient with chronic pain. Benjamin Castleman in pathology was a superb teacher and tireless investigator.

There are so many, many more who provide rich memories and anecdotes. One of the more graphic and lasting impressions was made by Carl Walter who taught the basic surgical scrub technique. Who can forget the



**"We** were never fully convinced by those all-knowing upperclassmen who kept telling us, 'If you were accepted, you'll probably graduate.'"

lampblack and oil rubbed into the hands followed by prolonged ineffective scrubbing of blindfolded neophytes. Merrill Sosman, the radiologist who could *see* cardiac murmurs on the chest film. How sad it was to observe him going around the Brigham offering to put out others' cigarettes after he himself developed lung cancer. Dwight Harken will be recalled for his daring and his sense of timing in the high drama of early open heart surgery.

As interns we received \$300 — for the year! But we were thrilled to be free of the costs of tuition. Sundays meant family dinner together, as wives and children invaded the hospital to spend some time with Daddy. On any given Sunday at 1 pm, one could readily savor the excitement — nay, say, chaos — of what looked like a rerun of the San Francisco earthquake or the Chicago stockyards. With the rosy glow of retrospection, we tend to blur some of the margins of our experience. In particular we mute the many hardships and earlier traumas associated with being a house officer. We shrugged off some of the unresolved problems that were later reflected in divorce, or other family catastrophes.

We should also acknowledge those members of our class who have already made their lifetime of contribution: Freeland Barbour, Kenneth Borg, Walter Clason, Leonard Garren, Phil Gordon, Tilbert Gyorgy, Edward Haley, Gwyn Lile, Danny Pugh, Emanuel "Jocko" Roth, Brainard "Bud" Smith, Sumner Wood, Jr., Charles Ulrichs. These losses underlie feelings of sadness, sorrow and nostalgia. But we are encouraged, even in the depths of despair, to reach out and rejoin the race. Which brings me to my title — "Like Wow, Man . . ." It is supposed to indicate the changes we have seen come about, reflected in how language has changed. Many new words are descriptive and create immediate visual images. "Hang loose," for example, does not represent an inguinal hernia or a prolapse but rather a state of emotional ease. "Uptight" is a marvelous expression especially if you've received a notice of an impending audit by the IRS.

I'm happy to report that those detestable nothing words — "y'know," which used to precede every phrase

and signified nothing more than incoherence and avoidance of communication, are now "like," *passé*. Guess what has taken their place? You're so right. The word "like" is inappropriately used whenever one syllable doesn't easily slide into the next to create a slurred mumble. "The whole scene is enough to blow your mind and leave you spaced out unless you can get your shit together and keep it cool." One cannot help but wonder what has become of "mother" in this current jargon. With women's lib, she has been torn from the sanctity of her home to become a hyphenated insult. Language as a reflection of social and cultural change is a special field of study, which we must leave to the experts.

Finally, I'd like to tell you what I've been doing for these past six months. I am a dentist, board certified as an oral and maxillofacial surgeon, and currently on a six month sabbatical from my position at Montefiore Hospital and Albert Einstein College of Medicine. I decided to spend this time as a medical intern getting updated and reoriented to the fast moving pace of changes in medicine.

It was a physical, intellectual and emotional challenge that I can enthusiastically recommend to many of my classmates who may be feeling the weight and worry of twenty-five years. Obviously one cannot easily relinquish responsibilities of daily practice for an extended period to return to academe. Yet, it was terribly important for the benefit of my patients, my residents and my own sense of competence. The ancients were wise in urging a sabbath-of-renewal every seven years.

Seven years ago, I graduated from the Albert Einstein College of Medicine after finishing the last two clinical years. At that time I was employed as the half-time chief of the department of dentistry at Montefiore Hospital. As you can readily see, I am a firm believer in continuous education. Having enjoyed my last direct exposure as a clerk and subintern on a medical floor in 1972, I was impressed to see the changes both diagnostic and therapeutic that have been brought about in the interim.

Fiberoptic endoscopy has made dramatic advances in several fields: gastrointestinal diagnoses via direct

visualization and selective biopsy have transformed the gastroenterologist into a more aggressive clinician. Fiberoptic bronchoscopy has also become an important tool of the pulmonary medicine specialists as well as of gynecologists, urologists and anesthesiologists who are applying this new technology to their respective needs.

Sonography or ultrasound, used in a limited way in obstetrics seven years ago, now provides one of the main diagnostic aids for defining abdominal problems. Phono and echocardiography and Swan-Ganz catheterization have been brought to the level of sophisticated everyday clinical use.

Computerized tomography, especially for problems involving the head, has had a profound impact on radiology, neurology and neurosurgery. It has become an indispensable diagnostic instrument; despite its great cost there really is no more effective, less expensive substitute. Already newer, improved head and body scanners are making their appearance. Radioimmunoassay has come out of the laboratory to be used more by clinicians in helping to determine levels of hormones and important medications. Nuclear medicine scans that were in their infancy seven years ago are now used daily. The applications of computer technology to medicine, which have experienced explosive growth in the past decade, will become even more commonplace, with specific knowledge a prerequisite for using computers effectively.

Other equally impressive examples abound of the avalanche of new information and technology facing us. Trying to keep current even in one's own field means reading journals, and attending hospital staff meetings, national and international programs. If you can arrange it, I would suggest that you recapture some of the feelings of involvement you once both cursed and enjoyed.

Develop your own mini-residency, be it for one month, six weeks or whatever. You will learn, you will teach, and you will get to understand and be rather proud of the young doctors who work alongside you. Then, you too will feel more "like wow, man, my head's together, my karma's movin' and it's c-o-s-m-i-c!"



# Politics, Politicians, and the Psychoanalyst

by Edward Messner

## The making of a public servant

The title of this talk was suggested by our reunion committee. As a politician, I thought that it was a good title because it seems to promise a lot without actually saying so. An alternate title, suggested by my daughter, Ellen, is "Lie, Cheat and Steal."

After the program for Alumni Day was mailed out, two former members of the admission committee were overheard in Building A commiserating with each other about one of their rare mistakes. One of them said, "It's a pity about Messner. Back in 1950 he really showed promise; but then he went into a decline and ended up in psychiatry." The other replied, "Worse than that: he became a psychoanalyst. Now I see that he has gone into politics. What a disaster!" That's a pretty sad record, I'll admit. The reunion committee, possibly as an effort at rehabilitation, offered me equal time to respond.

My political career began when my children entered the public schools in Amesbury, a town in Massachusetts with a population of about 14,000. The school system was in a shambles. The school committee hired and fired

superintendents almost annually, conducted too much of their business in secret, and seemed to debate for hours about such matters as the colors of the shoelaces for the high school varsity football team.

Now, I have nothing against football — except possibly that it is the only sport that exceeds trampolining in producing quadriplegia among students. But I thought that such things as reading and math might also have some relevance in school committee deliberations.

The condition of the school system was so bad that it penetrated even my political apathy, but only to the extent that I urged some of my more stable neighbors to run for election. They claimed that they were too busy, and urged me to run. I said I was too busy also, and besides, my only knowledge of politics came from reading the *New York Times* on Sunday. They argued that it showed that at least I could read. The argument that persuaded me was that I couldn't do a worse job than the incumbents.

In entering the race, I promised myself that if politics pushed me toward becoming a liar, a cheat, an opportunist, or a betrayer of public trust, I would withdraw. That was more than eight years and three elections ago. No doubt, my former teachers, my classmates, former members of the admission committee, and others will feel reassured when I say, "I am not a crook!"

My first campaign consisted of a series of informal gatherings at the homes of people who were interested in my election. They served coffee and cookies, and expected me to talk. My



"The variety and urgency of pressures from so many directions produce a special kind of stress on the elected official."

personality, which hadn't been much to begin with, by that time, had been worn down by psychoanalytic training to a condition of professionally unobtrusive drabness. Since I obviously lacked charisma, I focused on issues.

The people who attended the coffee hours looked to me with hope, confidence, and trust. They aroused in me reciprocal feelings of responsibility and protectiveness. Some of their attitudes were reminiscent of the way

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*Edward Messner '54 has been working in the department of psychiatry at the MGH since 1962, mainly teaching residents. He also has a private practice of psychoanalysis and psychotherapy in Boston. Borrowing the phrase used to characterize the father of Alice B. Toklas, "a quiet man, who took things quietly but felt them deeply," Dr. O'Brien referred to his classmate as "quiet no more. He brings a rural North Shore viewpoint on the universe."*

that many patients view their physicians, that is, before the malpractice lawyers get involved. But these people were not approaching me as their doctor, and certainly not as their psychiatrist. I was their political candidate. That was my initial direct observation, from the inside, of the details of the relationship between an elected official and his constituents.

A similarity with another aspect of medical experience arose after the election. It was like HMS I all over again when commonplace items such as arms, legs, eyes, and ears turned out to be more and more complicated the closer that one looked at them. There is an enormous amount to be learned about the operation of even a small public school system like mine. Municipal finance, school law, and collective bargaining are a few of the subjects of which I had been totally ignorant.

In addition, I had to learn about some secret functions. Budgets, for example, are devices used by administrators to influence the operation of the school system. Collective bargaining is used by teachers' and other employees' unions to warp the rules to suit themselves. The task requires more knowledge than most politicians possess. If you wonder why most of us elected officials appear so inept and incompetent, it is because we are.

A school board is mainly a legislative body. It makes the rules or policies for the school system within constraints set by federal and state statutes and regulations. Occasionally, it serves quasi-judicial functions, as in some disciplinary situations, or executive functions, as in the selection of a superintendent of schools.

Of the approximately 100,000 school board members in the United States, most are elected. Usually the only prerequisites for office are that we be of voting age and reside in the district we serve. The vast majority of us serve part-time and without pay. We belong to a great horde of citizen-politicians who govern many of the towns and cities, and even some of the counties, of this nation.

One of the more pleasant discoveries of my political career is that most citizen-politicians are honorable people. Like my fellow members of the current Amesbury School Committee, they are honest, hard-working and

sincere. They care about their communities and their constituents with admirable generosity.

As a result, many citizen-politicians are surprised and hurt when they are reproached for their efforts. Most people are poorly prepared for adversary relationships, and often, mere disagreements are felt as attacks. Yet political situations swarm with disagreement. Individuals and groups struggle to obtain power, to get things done in their own way.

Budgeting of public funds offers some good examples. School principals slant their budget proposals toward the programs that they prefer. The superintendent of schools has his own favorite projects. Some parents want more and better school buses. Teachers and other employees want higher pay. Union officials are concerned about their own jobs, and want more union members in order to have more dues-payers, so they bargain for less and less work for more and more people. State agencies and many parents demand expenditures for special education. Federal agencies and members of disadvantaged groups demand funds for equal opportunities. The paradox is that everyone wants school expenses to be reduced because no one wants to pay higher taxes.

Not only do all of these groups attempt to influence the school board, but school board members have their own priorities and try to influence each other as well. Meanwhile, our

spouses and children urge us to stay home and not go to so many meetings. The variety and urgency of pressures from so many directions produces a special kind of stress on the elected official. When the demands of the pressure groups are publicized in newspapers or other media, the stress is amplified.

The plight of the elected official often worsens following an important vote. Some of the individuals and groups that failed to get what they wanted may respond vindictively. An accumulation of such vengeful outbursts can be burdensome emotionally — at least for people who have had less than five years of psychoanalysis.

Politicians respond to these pressures in accordance with their individual adaptive repertoires. A reaction that seems to occur frequently is a sense that they are entitled to money, special privileges, or other benefits that are beyond the statutory compensation of the public office. One effect then of the barrage of urgent and conflicting demands is to arouse corresponding wishes in politicians. Hunger is contagious. They say, "Everyone else is getting something out of this, why not me? After all that I have done for them, I deserve some of the same."

Therefore, the next time you hear a politician tell you that he is not a crook, please consider that maybe he believes that he is entitled to whatever it is that he is stealing.

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### The Meeting-hour

The whisper of the meeting-hour  
echoes through the leaves  
half-hoping the time hasn't come  
for this reunion of dreams.

Words reverberate in dusty sunlight —  
"you haven't changed a bit!" . . .  
"we're all so proud of your success!" . . .  
Teeth posed in photo-flash joy.

Sighs intermingle with hasty guffaws —  
professional wrinkles trapped  
in smiling denial, pretending indifference  
to the loss of youthful vigor.

Children's laughter breaks the moment,  
echoes through the leaves . . .  
half-despairing that time will pass  
for realizing dreams of inner peace.

— Mary E. Sunday '80







*Derek Denny-Brown, M.D. (center) spends a few profitable moments with Harry Solomon '14 and his wife Maida.*

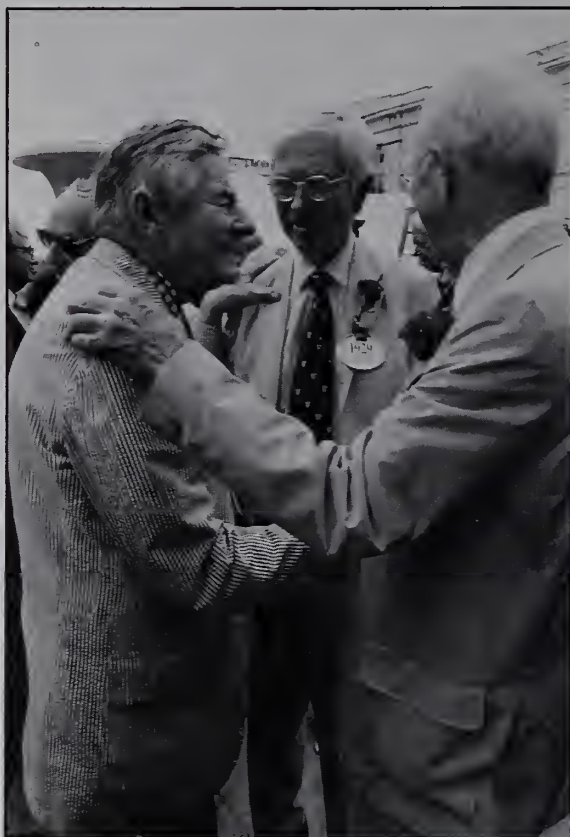
## *Before, During & After*



*The morning's program had lots of laugh lines.*



*Sorry, this table is taken.*



*A principal Alumni Day refrain: finding out about one another's lives.*





*Reunion ritual: HMS '54 is prepped on having its class picture taken.*

*Eric Sanderson '37 composed an ode to the annual reunion phenomenon following the celebration of his class's return to the Quadrangle two years ago.*

### **Life Goes on After Forty, but it's Slower**

Now forty years of life are spent  
Since we departed Harvard's tent  
To wander in the wilderness.

We toddled outward on life's track  
And now, mature, we totter back  
To reminisce and reassess.

We'll note the alterations  
That the passing time has wrought,  
And some we will approve of  
And others maybe not.

We'll take a look at Harvard  
And its progress we'll discuss.  
We will also stand inspection  
And let Harvard look at us.

They will note as we assemble  
When reunion time is due  
That the Class of Thirty Seven  
Is a fairly motley crew.

We're tall and thin, we're short and stout.  
We've some with hair and some without.  
Some have aortas full of zing  
While others are replaced by string.  
Some jog without thoracic pains  
And some contain transplanted veins.

While some are famous, most are not,  
And those who aren't will say, "So what?"  
Though most are cheerful, some are gruff.  
I could go on, but that's enough.  
A capsule look at us, 'tis true,  
But now let's take a look at you.

When you consider Harvard  
Do you think it's only there,  
By Oscar Tugo's Circle  
And Johnny Harvard's Square?

Wrong! Harvard is ubiquitous.  
This means it's all around,  
From scenic Boothbay Harbor  
To the shores of Puget Sound.  
From sunny old Fort Lauderdale  
To San Diego Bay.  
And this is just within the  
Continental U.S.A.

Putting Harvard in perspective,  
We've learned more what it's about  
From the outside looking inward  
Than from inside looking out.

And we're still a part of Harvard  
Though we fish a different stream  
And it's years since we departed  
From those Halls of Academe.

Let us gather in the evening  
And let's share a social cup.  
Let's lie and brag a little  
And let's size each other up.

And when the evening's over  
Please take note and don't forget,  
Though we're definitely senior  
We're not really senile, yet.

As you watch our numbers dwindle  
Please feel properly bereft  
For though our feet have strayed from Harvard  
Our hearts have never left.

— Eric R. Sanderson

# Some Lessons from Primitive Societies

by Lot B. Page

By an accidental conjunction of career and hobby interests, I have spent some time over the past dozen years studying primitive populations in several parts of the world. I have done this work in cooperation with cultural and physical anthropologists, and, with appropriate apologies, I will mix medical and anthropological observations in my remarks and will add supplemental data ad lib from the literature. Very little of what I have to say is original with me.

First, let me defend my use of the term, primitive societies. As defined by J. V. Neel, " 'Primitive' designates a society which is preliterate, employs very simple agricultural and manufacturing techniques, and is primarily organized around concepts of kinship.' "

The word "primitive" will seem pejorative only to those who confuse technological knowledge with intellectual superiority, or who fail to appreciate the highly sophisticated mental processes by which such societies achieve equilibrium with their environment.

Western culture has a long established habit of subjugating less technically advanced societies and making them conform to its beliefs and practices. The remaining few autonomous societies are rapidly being swallowed up and homogenized, and all will be gone by the end of this century. In the little time left in their hour glasses, the primitive cultures afford a priceless resource. They provide glimpses of our own pre-industrial origins. They show us some successful solutions in the microcosm to problems of food supply, population control and societal living, and some insights into the origin of diseases such as hypertension and coronary heart disease.

To anthropologists, the primitive societies also offer the last chance to piece together, from living evidence, the history of our species' prehistoric migrations and the genetic relationships among different races and groups.

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*Lot B. Page '49 is chief of medicine at Newton-Vellesley Hospital and professor of medicine at Tufts School of Medicine. Commented Dr. O'Brien, "He has had a career-long interest in hypertension, both at the bench and in the field, and he brings a special perspective in time and place."*



Late 20th century views on the ruggedness of jungle life



The prevalence of common diseases and causes of death are radically different in primitive societies than in industrial countries. There are over twenty well studied societies in which blood pressure never rises with age, and hypertension is unknown. Other cardiovascular risk factors are also absent as is electrocardiographic evidence of coronary heart disease. These societies represent many different races, diets, climates, and modes of subsistence. It has been repeatedly shown that when people from these societies migrate, or adopt the ways of western civilization, they rapidly acquire rising blood pressure, rising plasma lipids, and, in due course, major cardiovascular morbidity.

No group has proven to be genetically immune from these biologic changes. Older studies postulated that malnutrition and chronic disease were responsible for the low blood pressure of primitive populations, with restoration to "normal" rising pressure a result of the health benefits of acculturation. Absence of cardiovascular disease was also attributed to shortened life span of primitive people. More recent studies have disproven both these hypotheses. For example, superb athletic performance and maximal oxygen consumption, (rivaling winners of the Boston Marathon) have been demonstrated in primitive Africans; physical and biochemical evidence of malnutrition has been found absent in eight unacculturated Melanesian populations; and an excellent diet and extraordinary physical stamina have been found in Mexican Indians, who amuse themselves with kick-ball games, in the course of which they run continuously from dawn to dark, covering over 200 miles in two to three days, all at an altitude of over 8,000 feet above sea level.

With regard to age, careful demographic studies by anthropologists, using tedious methods of triangulation against known events, have established biologic ages in primitive societies to a confidence limit of two to three years. Substantial cohorts of men and women in the seventh, eighth, and even ninth decade have been found who remain free of any sign of degenerative vascular disease.

Acculturation into the ways of western civilization affects every aspect of life in primitive societies, and



**"Modern anthropology is a science which seems to have come of age just too late, when its subject matter is about to disappear."**

often occurs very rapidly. Religious belief, diet, mate selection, social position, physical activity, and mode of subsistence are all radically changed. It has often been postulated that psychosocial stresses brought about by these changes are primarily responsible for rising blood pressure and the appearance of risk factors in acculturating populations.

Stress is notoriously elusive and difficult to quantitate. Nevertheless, numerous efforts have been made to measure it using questionnaires and observations to detect changes in attitudes, in social mobility, child rearing practices, diet preferences and social interactions with white society. Computer generated scores have also been used to quantitate change from traditional to "modern" patterns of activity. Results of such studies have consistently shown blood pressure and other risk factors to be related far more closely to physical factors and dietary change than to psychosocial stress factors. Changes in body weight, salt intake, and use of animal fat account for most of the changes in blood pressure and blood lipid levels in acculturating societies. The findings have been disappointing to those who are wedded to the stress hypothesis.

The powerful effect of diet, and especially the effects of body mass and sodium intake on blood pressure trends cut across varying degrees of acculturation. Hypertension is completely absent only among low salt

societies throughout the world from the arctic tundra to equatorial jungles. Interestingly, hypertension is a serious problem among lean unacculturated pastoral nomads in Iran whose salt intake equals or exceeds that of Americans. The single most important factor in determining serum lipid levels in population studies all over the world has repeatedly and consistently been shown to be intake of animal fat. These are tangible facts with practical public health implications for all societies, although only feebly addressed up to now.

Modern anthropology is a science which seems to have come of age just too late, when its subject matter is about to disappear. Nevertheless, the observations of the present generation of anthropologists have come in time to question or reverse many of the time honored assumptions about primitive societies that were based on conclusions of earlier generations of observers, less schooled in objective data collection. Several different modes of subsistence in primitive societies have been subject to revised interpretations.

Hunter-gatherer societies are thought to be the direct ancestors of the European societies, which grew up after the Neolithic revolution when techniques for settled agriculture and the domestication of animals were developed. A dismal view of hunter-gatherers has been the universal verdict of an earlier generation of an-

thropologists. Hunter-gatherers are usually described as technically incompetent and committed to continuous labor to avoid starvation. They are viewed as having no technique to store surplus, and no time to build a material culture. Recent studies of the few remaining hunter-gatherer societies have reached quite a different set of conclusions. In fact, Marshall Sahlins has described them as "the original affluent society."<sup>2</sup>

Studies of aborigines in Arnhem Land and Kalahari Bushmen of Botswana have shown that both groups have a varied and well balanced diet which is readily obtained with an average work day of four to five hours. The quest for food is typically intermittent, with frequent days off spent resting and socializing. They move often, thus assuring that food sources will be available without excessive effort. They have few goods, but do not consider themselves poor. They have no desire to acquire material goods, which will only encumber them and reduce mobility. They have little motivation for storing surplus, since experience has taught them that food sources are usually available wherever they go. One group studied in Africa had considered turning to agriculture, and rejected it "mainly on the grounds that it would involve too much hard work." These observations on hunter-gatherers are all the more impressive because they were made on groups who had long since been pushed out of the more fertile and promising areas of the world, and into poor barren wastelands that no European nation wanted to claim.

Another mode of subsistence that has supported primitive populations for thousands of years is bush-fallow farming. As practiced in the South Pacific, and elsewhere, the farmer slashes and burns an area to make his garden. After a year or two of growing crops, he moves on to another area, finally returning to the first field after eight or ten years when the secondary growth has restored its fertility. This practice, wherever it has been encountered by Europeans has been immediately denounced as inefficient, wasteful, environmentally destructive, and incapable of forming the basis for advancing civilization.

Careful studies in recent years of this form of agriculture show, instead,

that bush-fallow farming is remarkably efficient, providing adequate nutrition with cultivation of as little as 0.2 acres per person.<sup>3</sup> The farmer, like the hunter, works far fewer hours than his counterpart in our society, and has abundant leisure time. Moreover, the primitive method is far less destructive to the tropical environment than are the advanced methods of agriculture that have replaced it.

A third mode of primitive life is that of small isolated oceanic islands and atolls. Traditionally such places have been considered among the harshest and most tenuous environments for permanent human habitation. Food sources are uncertain and monotonous and water supplies dangerously limited. The virtually total seclusion of the population also has been cited as having a negative effect. Again, recent studies give an opposite picture. Food supplies are adequate and varied; leisure and material culture abundant, and people remarkably healthy and generally well adjusted. Certain small island dwellers that we have studied, although literally semi-aquatic, have contrived to avoid sodium chloride in the diet, and are among the low blood pressure populations mentioned earlier.

With all I have said I do not wish to revive the notion of the "noble happy savage." There are stresses in primitive society, different from those in industrial nations, but equally severe. Social structure is rigid, the penalties for deviant behavior are extreme. Trauma and infectious diseases are frequent and serious. Life is uncertain and often short.

At the same time, it seems generally true that the primitive societies have survived, and even thrived, by achieving an equilibrium with their environment that provides them with adequate nutrition, frequent leisure, and apparent life satisfaction. They have few material goods, but have adopted the Zen strategy: want not, lack not. "They have not curbed materialistic impulses. They simply have never made an institution of them."<sup>2</sup> Poverty is a social status, and as such is an invention of civilization.

Edward O. Wilson, whose theories of sociobiology have excited some recent controversy, argues that human genetic makeup was shaped by the events of the ice age, and is better

adapted for coping with primitive than with modern problems.<sup>4</sup> Most people develop fears of lightning, spiders, and snakes more readily than fear of guns, machinery, and nuclear power plants. The tendency to classify others into friends and aliens and quickly to resort to violent solutions to disputes has far less survival value for modern nations than for primitive tribes. It seems hardly necessary to say that the images and goals of modern industrial life are badly tarnished, and alternatives are scarce. The major structures of industrial civilization are unlikely to be dismantled, no matter how fatally flawed and hell-bent they seem. Still, it may not be too late to look in some other directions, to see where we came from and to plot some possible escape routes for ourselves and our descendants.

It would be absurd to suggest that society should return to a paleolithic mode of subsistence. But it is not unreasonable to seek healthier patterns of diet and activity to combat the diseases of civilization and to look for enlightened ways of regaining equilibrium with the planet we live on. There may still be other important lessons to be learned from the last of the world's primitive societies. If so, our efforts to learn them must be quick and efficient because their time has almost run out.

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# Adventures of an Adjunct

by Neill K. Weaver

## Being an unattached faculty member has its compensations

Webster's *New Collegiate Dictionary* defines adjunct as (noun), "something joined or added to another thing but not essentially a part of it," and as (adjective), "attached in a subordinate or temporary capacity to a staff." As one cast in the role of an adjunct, I am not particularly upset by the somewhat anomalous designation of being "something" attached to but not an essential part of "another thing" — even though the "other thing" may be a medical faculty — or of being assigned to a "subordinate" position; after all, there can be only so many chiefs. I would, however, take issue with the "temporary" characterization, having held an appointment of adjunct professor at one medical school for more than twenty years!

To account for this situation, I can report a relatively early departure from the full-time faculty ranks, followed by a series of part-time posts in internal medicine, and later on in environmental hygiene and occupational medicine, some of which persist to this day. Involvement in an industry-

supported research program led to interactions with faculty and graduate students at a number of medical and research institutions. Invitations were received to provide a lecture, to conduct a seminar, or to develop a research project with a team of university investigators. Consequently, a career of more than twenty years as an adjunct — or, more properly, as some sort of visiting fireman — has provided an unconventional opportunity to survey the medical education scene

**"The adjunct enjoys a special measure of academic freedom. Since all efforts are voluntary, tenure is of no concern."**



Neill K. Weaver '44, who left academe for a career in occupational medicine in the petroleum industry, says that he "maintains sporadic contact with institutional teaching as an adjunct professor." More precisely, he is clinical professor of medicine and professor in the department of environmental hygiene at Tulane University School of Medicine. He had been connected with Exxon and since 1973 has been at the American Petroleum Institute in Washington, D.C. He is director of API's department of medicine and biological science. "Certainly reveals an instinct for being able to pick a winner," quipped Dr. O'Brien.

at numerous institutions; I have been able to bring to this empirical study a relatively detached and discontinuous objectivity, and an unmeasured but undoubtedly large element of personal bias, for which no apology is rendered. A pot pourri of these observations follows.

First of all, life in the ivory tower ain't necessarily all that it's cracked up to be. Attributes of academe, such as the halo of purism or the mantle of scientific freedom, are sometimes more visionary than real. Success in grantsmanship, for example, seems increasingly to call for a degree of pragmatism, even political savvy, whatever the source of funds. Faculty organizations carry the elements of hierarchical expediency. Attending faculty meetings as a "subordinate" adjunct includes the privilege of selecting a back row seat, which is a marvelous observation post. From this vantage point, and with a degree of insight into the local situation, one may take note of the hidden agendas, jockeying for position, one-upmanship and various other games being played. And, to a trustworthy outsider, faculty at all levels, research fellow to distinguished professor, have been known to rail against on-campus problems, even before the first martini has been poured.

So, professors are human, and the university is not yet utopia. For both of these deficiencies we are indeed fortunate. In proper perspective, the above-listed faults are minor when compared with the opportunities for achievement in the scholar's way of life. Success is rewarded with levels of esteem and honor that are rarely, if ever, gained in other vocational pursuits. Persons of such distinction are present at this gathering.

Having been brave and foolish enough to comment on faculty, a critique of the student body can be launched with gusto. But first, a concession must be made. A history of this adjunct's teaching endeavors with undergraduate students reveals, on certain occasions, a notable lack of success. No real difficulties were encountered in the formal hospital instructional program from intern to resident to fellow to associate to visiting physician. Nor were problems noted in clinical sessions or didactic lectures, as long as the subject matter covered conventional internal medicine,

allergy or cardiology. It was apparent, however, that efforts to provide some insight on rehabilitation of cardiacs failed to generate any spectacular enthusiasm on the part of the students.

My teaching trouble began after moving from the campus to industry. Invitations to lecture to medical students on preventive medicine, environmental hygiene or occupational medicine were received and foolishly accepted, with predictably dismal results. While it was established that perhaps a third of a fourth year class can be kept awake by a contrived *tour de force* of occupational horror stories, I quickly came to view this as a prostitutional approach beneath my dignity. This brings up a desirable attribute of the adjunct: he or she enjoys a special measure of academic freedom. Since all efforts are voluntary, tenure is of no concern. The adjunct is beholden to no department head, since there is little to be gained by firing him or her. While I trust the faculty at the Harvard School of Public Health has devised a palatable format with which concepts in preventive medicine are presented to medical students, my teaching preference definitely rests with the graduate level.

A lecture, or preferably a seminar, for a master of public health class can be an interesting and challenging assignment. The students — physicians, nurses, industrial hygienists and sanitarians, plus a number of special foreign students, representatives from the military services, predoctoral candidates and faculty members — possess a maturity well beyond the pathology/therapy interest of undergraduates, and a sincere dedication to the prevention of disease is evident. In earlier years I labored under a compulsion to provide a great deal of factual information — an approach not unknown to certain HMS faculty members in the early '40s. A humbling experience occurred during the break in a two-hour class at Ann Arbor. I was approaching the coke machine around a corner and overheard a group of students disparagingly remark, "That g—— d—— visiting prof is a racehorse — why can't he slow down?" Fortunately, I took the hint, and the pace of the last half of the lecture was much slower.

A still more relaxed class occurred at Tulane a few years ago. When I ar-

rived for a Friday afternoon session late in May on occupational carcinogenesis, the department coordinator warned that all term papers had been submitted, an optional final exam had been completed, and it was the last class of the school year. Under the circumstances, attendance was remarkably good — virtually every student was present, no doubt attracted by the two cases of beer that were graciously shared with the adjunct professor!

My research activities have provided an extended base for faculty interactions. Contrary to what political writers would have you believe, the American Petroleum Institute (API) is largely a technical and scientific organization that sponsors research on behalf of its member companies. With items like the national energy policy and the gasoline crisis grabbing the headlines, it has been possible to maintain a low profile for health-related research, most of which is carried out in university centers, with all reports and findings released through scientific channels. The projects encompass a wide spectrum of subjects relating to potential petroleum industry effects upon the worker, the consumer, the general public and environmental ecology. Coordination of the API medicine and biological science program has resulted in visits to university-centered investigators on the East Coast in Boston, Martha's Vineyard, Providence, New York City, Baltimore, Yorktown, Raleigh and Miami, and on the West Coast in La Jolla, Los Angeles, Menlo Park, San Francisco, Berkeley and Seattle, plus a dozen or so campuses in between. A few of the forty to fifty current or recently completed projects include those at the top of the East Coast list:

- Boston: Dr. Irvin Blank, a venerable investigator in the MGH department of dermatology, is providing valuable information on percutaneous penetration of hydrocarbons in an *in vitro* system — information which will be applicable to *in vivo* test systems in Seattle and San Francisco.
- Martha's Vineyard: A unique lobster hatchery is assessing how oil and lobsters mix, or, what will happen to *Homarus americanus* in the event a "gusher" is hit off Georges Bank. While the adult lobster is a bottom-dweller, a 5-moult larval stage exists as

neuston, at or near the surface of the sea. This obviously represents a potentially vulnerable stage in lobster development in the case of an oil spill. Happily, the little critters, which are intensely cannibalistic, tolerated well a "worst case" oil spill, simulated in the laboratory, with equal survival in exposed and control populations.

- Providence: University of Rhode Island marine biologists are investigating an apparent hemocytic neoplasm in — of all things — the soft shell clam. The disorder was discovered by Environmental Protection Agency scientists investigating morbidity in clams following an oil spill in Maine; understandably, they attributed it to the spill. Further investigation, however, revealed that the disease occurs in pristine as well as contaminated areas and that it is transmitted by flowing seawater in the laboratory. All evidence points toward isolation of an oncogenic virus in marine bivalves.

- New York City: A team of epidemiologists at Memorial Sloan-Kettering Cancer Center is prospectively following a population of more than 80,000 refinery and petrochemical workers with respect to mortality, morbidity and cancer incidence.

- Bermuda: These islands literally sweep the sea currents emerging from the Sargasso sea vortex, removing debris that includes an extraordinary amount of "tar balls." Decades of studies at the Bermuda Station, with detailed records of shoreline flora and fauna, permit an assessment of impact, if any, by floating "tar." Fortunately, no significant changes in biomass have been detected, and it's a great place for site visiting!

Obviously, no logical summary can be drawn from this anecdotal mélange. But in the tradition of Alumni Day I shall draw two conclusions:

1. A physician with a propensity for research should not hesitate to expand his or her purview to encompass broader environmental and ecological investigations; the resultant interactions with scientists in more remote biological fields can be mutually rewarding.

2. HMS and similar institutions, their students and faculties (including adjuncts!) contribute in many ways to ameliorate societal ills, and merit our support and admiration.



This must be an illusion. We graduated only yesterday. And we're not any older, just better. Twenty-fifth reunion jokes can't refer to us — no one of us has become so fat or so gray as to be unrecognizable. And we just don't fit the prototype that class reunions are full of people who graduated from colleges that they couldn't even get into today. People don't change — they only become more so.

It was then just yesterday when, weary of anatomy, histology, biochemistry, and Vanderbilt Hall, Tom Lehrer provided us with the escape we needed. His parodies on religion, on politics, on the military, and on American culture made us realize that the outside world was at least as vulnerable to criticism as we thought.

Remember his old dope peddler, with his powdered happiness? His cry against pollution, warning that all was all right if you "don't drink the water and don't breathe the air." Could that have been twenty-five years ago? And when on occasion we became hostile to the people around us, we felt comradeship with Tom Lehrer as he proclaimed for Brotherhood Week, "I know there are people in the world who do not love their fellow human beings — and I just hate people like that." But he always had the happy conclusion of "Turn on the spigot, pour the beer and swig it, and gaudeamus igit — ur."

It may be that fifty years hence Tom Lehrer will be required listening in American history courses as a parody of the American experience; even now he remains relevant. Remember his satire on the atom bomb — the cowboy song describing the mushroom cloud in our western desert? "Where the scenery's attractive; and the air is radioactive; oh, the wild west is where I want to be." It served

# Has Anything Changed in 25 Years?

## Tom Lehrer Revisited

### Rallying 'round the Quadrangle with a former (but still au courant) hero

to reinforce our concern and uneasiness about Daphne, the radioactive sheep quartered behind Building B, especially the night she escaped and ran away down Avenue Louis Pasteur. Today we have the Three Mile Island incident — emphasizing that since the invention of the atom bomb, science has spent less time studying the origin of human beings and more time on what our finish is to be. Despite this, we hear again and again that science is a wonderful thing, yet it has not succeeded in maximizing pleasure or in minimizing pain, and that's all we ever asked of it.

But back to Tom Lehrer. Remember his hero, Nicolai Ivanovitch Lobachevsky, who proclaimed,

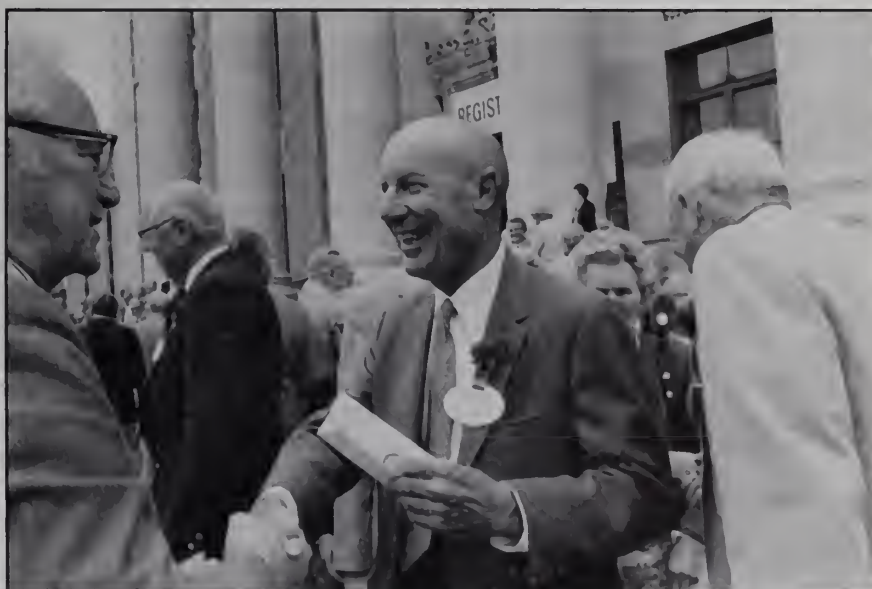
"Plagiarize, let no one else's words evade your eyes; remember why the good Lord made your eyes; so don't shade your eyes; but plagiarize, plagiarize, plagiarize — only be sure always to call it please research."

Nowadays the good word is that if you steal from one person it's plagiarism; if you steal from ten people it's research; but if you steal from hundreds you're a scholar. Well, speaking as a scholar . . .

We are all scholars about the matter of rearing children. Is there anything different about our children — many of whom are now in college or even in medical school? Has anything changed in twenty-five years? We know that children are harder to raise

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*Nanette K. Wenger '54 was introduced as "one of the better known cardiologists in the country." She is professor of medicine at the Emory University School of Medicine and director of the cardiac clinics at Grady Memorial Hospital. She is the immediate past-president of the Georgia Heart Association, a past vice-president of the American Heart Association, and president-elect of the Council on Rehabilitation of the International Society of Cardiology.*





“What is it that the public says about us? Ralph Nader classifies practicing doctors into three types — expensive, costly, and exorbitant.”

than they were in the past (every generation's parents have thought so). We are also quite certain now that childhood begins with youngsters asking where they came from, and ends with them refusing to tell anyone where they're going. But probably the best message I can give you today is that fathers should carefully teach their sons how to earn money because mothers are intensively teaching their daughters how to spend it.

But let's return to our days on this Quadrangle — and to the inevitable 8 am lectures. What was characteristic of them? Certainly they fulfilled Herrnstein's Law, which says that “the attention paid to an instructor is a constant, regardless of the size of the class. Thus, as class size swells, the amount of attention paid per student drops in direct ratio.”

We know that those in the front row took notes; those in the second row read the *Manchester Guardian*, particularly the obituaries; and from there on backward, most everyone slept. But the one thing worse than dreaming you're at a lecture and waking up to find yourself there is the lecture where you can't fall asleep at all. Those hard amphitheatre chairs did all they could to discourage a quiet, peaceful hour of sleep.

Another characteristic of our morning lectures was the ambidextrous instructor encountered particularly in lectures related to steroid and porphyrin formulas in biochemistry. The ambidextrous instructor erased

with one hand while writing with the other. After we survived the first semester of anatomy, many of us became enticed by the new goddess, Research. Regardless of the project, we all learned some basic rules, facts, and precepts: under the most rigorously controlled conditions of pressure, temperature, volume, humidity, and other variables, the organism will do as it damn well pleases.

Finagle's basic rules for scientific research were an extension of the well-known Murphy's laws:

1. If anything can go wrong in an experiment, it will.
2. Experiments are always reproducible — they always fail in the same way.

3. The figure that is most obviously correct — beyond all need of checking — is always the mistake.

4. In any experiment, first draw your curves — then plot your readings.

5. No matter what the final result, there is always someone eager to misinterpret it.

This was the beginning. We were encouraged to broaden our horizons, but were never introduced to the Law of the Reverse Learning Curve: wisdom and knowledge decrease in inverse proportion to age; it took us the next twenty-five years to discover that phenomenon. We were also encouraged to be innovative in our approach to all areas of life and science,

## FATHERS AND DAUGHTERS

Howard H. Green and Forst E. Brown, both members of the twentieth reunion class, have no trouble at all recalling one of their more eventful days at Harvard. When Internship Day arrived for them on Monday, March 16, 1959, they brought their infant daughters Carrie Alice Green and Mary-Lynn Brown to the ceremonies. A photographer caught the anticipatory looks (primarily of the babies) and the result became the cover of the May 1959 HMAB; it was captioned “empathy.”

Was the hand of fate at work? Dr. Green's incipient medical career took him to Hanover, New Hampshire and the Mary Hitchcock Hospital; he is now chief of staff at the White River Junction VA. Dr. Brown started out at University Hospitals in Cleveland, and eventually moved east to Hanover and the Dartmouth-Hitchcock complex, where he is associate professor of clinical (plastic) surgery.

We recently received a “twenty year follow-up report” from Dr. Brown. Their respective daughters are now the ones making career plans: Carrie, just graduated from Wesleyan, in maritime administration and international law, and Mary-Lynn, a senior at Duke, in medicine. Twenty years seemed to vanish when the two families got together over last year's holidays.



The Greens (left) and the Browns (right), then and now.





although we were never taught Merrill's Rule of Instant Status: society heaps honors on the unique, creative personality — but not until he or she has been dead for fifty years.

And while our minds were being nourished, we also had to nourish our bodies. We discovered the Laws of Institutional Food: everything is cold, except what should be. Everything, including the corn flakes, is greasy. Vanderbilt Hall served only food that was gray, food that was yellow, and desserts that shook.

Then, our years of glory — the clinical years — we were really to become doctors. As introduction, our instructors quoted to us from Voltaire, "Doctors pour drugs, of which they know little; to cure diseases, of which they know less; into human beings, of whom they know nothing." Today, given to us as equal morale boosters, paraphrasing both sides of the current conflict, we hear that specialists learn more and more about less and less until, finally, they know everything about nothing; on the other hand, generalists learn less and less about more and more until, finally, they know nothing about everything. Perhaps Erma Bombeck's rule of medicine is more logical. She only exhorts us to "never go to a doctor whose office plants have died." But we never had a course on office plants.

Many of us are now in clinical practice, and many remain in the Ivory Tower in a variety of roles. What is it that the public says about us? Ralph Nader classifies practicing doctors into three types — expensive, costly, and exorbitant. Plagiarizing from Mencken, we can characterize the Ivory Tower residents as those who can, do; those who cannot, teach. Those who cannot even teach become deans.

The past twenty-five years have also seen, among the many changes in medicine, the advent of Medicare. To the public, probably the best thing about Medicare is that it enables them to have diseases that would otherwise be well beyond their means.

It behooves us to remember that ours was the sixth class to admit women, although the fact of female presence here was not incorporated into the University charter until after we graduated. I remember my first day on the Quadrangle, when a dis-

tinguished senior professor welcomed me with, "In my day, women didn't go to the Harvard Medical School." Even today it seems that whatever women do they must do twice as well as men, to be thought half as good. But, luckily, this is not difficult.

Finally, what is medical school like today? A friend of mine visited his child and found that his son was taking the same course under the same professor that he had had twenty-five years ago, so he decided to pay a visit to the class. To his dismay, he found the same questions being asked on a test that he himself had answered. On this he challenged the old professor,

who replied, "Oh yes, I give the same questions, but as the years go on I keep asking for different answers."

And though old solutions are no longer the answers to new problems, perhaps, when we return for our fiftieth reunion the old answers may have been resurrected and, of course, we will all be as young, exciting, witty, perceptive, and innovative as we are today in the spring of 1979.

*With appreciation to Tom Lehrer; to Jay Baltezare of Western Public Radio for "The Comedy of Tom Lehrer"; and to Paul Dickson, The Official Rules, Delacorte Press, New York.*

by Guy S. Hayes

## Diddling With the Patient

Some advice on seeing things from the patient's perspective

To many, this may seem like a curious title for a discourse presented at such an occasion. As a matter of fact, "diddle" is an interesting word that conjures up a number of different images that vary with the individual. Some years ago it reached the headlines of Boston newspapers and created quite a stir. There were raised eyebrows, smirks, grins and other kinds of reactions —

*Guy S. Hayes '39 was involved with preventive medicine during thirty-four years with the Rockefeller Foundation, twenty-five of which were spent abroad. His last position, before retiring two years ago, was associate director for health services. Remarking that both E.B. White and Dr. Hayes are residents of the small town of North Brooklin, Maine, Dr. O'Brien added, "and that is a high sage density for any community."*

but one couldn't be sure whether it was the word itself, or the context that produced them. In any case, a look at Webster doesn't help a great deal; the colloquial synonyms of "diddling" are cited as "hoax" or "swindle." I wouldn't think of suggesting that these might apply here. Then there's the definition: "to waste (as time) in trifling," and finally, "dawdle" and "fool." Let's wipe out the latter and stick with "dawdle," which Webster defines elsewhere as "to spend time idly." That's the one I like because that's what I want to talk about. My thesis is that no matter what doctors, nurses or others associated with a large teaching hospital may consider "diddling" or "dawdling," the patient has a different view. In fact, for him or her it is vital.

One morning, forty years ago, I was one of a group of students on

ward rounds with Dr. Henry Jackson. There was a short break and we were all just chatting in the corridor. Suddenly he said, "You know, it's very difficult to get a straight answer out of a patient. You don't believe it? Come along — I'll show you." He then wandered over to a patient on the open ward. Taking a relaxed stance at the bedside, he looked the patient straight in the eye and said, "Mr. O'Houlihan, did you have a bowel movement today?" There was a brief pause, then the response, "Who? Me?" Dr. Jackson had made his point!

But let's look at the other side of the coin. Isn't it sometimes equally difficult to get a straight answer out of a physician? Particularly an answer that the patient can really understand? Of course the question assumes that

garden, the cat, and perhaps even about the next-door neighbor.

The real crunch comes from lying in a hospital bed, either uncomfortable or really hurting, and spending a lot of time just wondering — "What the hell goes on?" A torrent of thoughts flood through patients' minds — they need reassurance and they want some good answers. Most of all, patients want to talk things over with their own doctor, not just one of the house staff who happens to be on duty. And they want to do it right then — stat! Since that's impossible, they have to wait until morning but they're afraid that by then they may have forgotten some of the questions. So, in extreme cases what do patients do? Write down a list of questions on a piece of paper to refer to at the next opportunity, if time

this particular patient and his doctor there was a problem in communication. The trouble is that in the idiom of pathology, gaps in communication are not uncommon. Indeed, they are widespread. At least, they occur everywhere that I have been. The problem is more prevalent in the larger hospitals which, due to their size, tend to lose the personal touch that is the hallmark of most community hospitals. And it's not limited to inpatients. The problem is most notable in any overcrowded outpatient clinic anywhere, and even in private offices, if there are lots of patients waiting. Recently, out of curiosity, I decided to investigate whether other people felt the same way that I do about what I would call "the clam syndrome," as applied to some physicians in large

**"Most of all, patients want to talk things over with their own doctor, not just one of the house staff who happens to be on duty."**



the patient sees his or her doctor for more than a fleeting moment. Yet with a squad of house officers and students trailing behind, the patient can hardly get a word in edgewise; almost as bad is the late afternoon or evening visit when the doctor is finishing off a hard day, and home and a preprandial change of pace are clearly a necessity. After all, the doctor is a very busy person with a host of preoccupations and worries. In fact, most of the other people working in a large teaching hospital — nurses, technicians, administrative personnel — are in the same sort of bind. I understand this and can sympathize. But patients have worries too. Aside from their major concern about their illness, they are liable to worry about their home, family, the

be granted. When I was a house officer I had patients who occasionally did that to me and it drove me up the wall. Why was I annoyed? I realized later that it was only because I hadn't spent enough time with a given patient to relieve his or her doubts and anxieties, and that it was my fault, not theirs. But in the meantime, I defended myself by getting sore.

I don't want to get too personal, but having been a patient myself at various times in five university teaching hospitals, I think I know what I am talking about. I confess that at times I also had been tempted to write a list. Actually, I did once — out of sheer frustration — and I hid it for future reference, not under the pillow, but inside the pillowcase where it could be retrieved for a glance as soon as I heard the familiar tread of footsteps coming down the hall. But my little plot was foiled. In the interim somebody had changed all the bedclothes; I had forgotten about the list and, like so many good ideas, it must have gone down the drain.

That minor incident, although it happened quite a few years ago, says something. It indicates that between

hospitals. If you stamp around in a clam bed you may get soaked, but at least you know that clams are there even if you don't see much of them.

So I started my own little survey and questioned five people whom I knew had recently been patients in a teaching hospital. Admittedly, the size of the sample would make a statistician cringe. But the question was unbiased; the answers were not. They all had had communications problems and zeroed in on the doctor as the chief offender. Nurses are much, much better, but even they, when pinned to the wall with a toughy, demur and then parry with, "Well, you'd better ask your doctor about that." All very well, but when? And for how long? That's the whole point.

Let's get off the doctor's back for a moment and have a look at the administration. These are the experts in management. They are not visible, but their unseen tentacles hold a tight rein on most things that go on in a hospital. The bywords are "control" and "money." But consider what happens to the average patient. Shortly after admission he or she is lying in bed, apprehensive and not looking forward



to the next morning's surgical procedure. A long afternoon is launched by what turns into a parade of "blood-letters" who march in singly to do their thing about every hour or so. Soon the patient begins to wonder why all this couldn't have been done with just one bleeding. Meanwhile the blood-letters alternate with the "specimen hunters" who eventually litter the bedside table with their goodies and a host of instructions on where, what, and how to produce. In terms of the seemingly irrational, however, Act III, Scene 3 occurs at the end of that first day — an hour or so before midnight. An orderly appears with a wheel chair or stretcher and, with a well-rehearsed opening line, says cheerily,

"We're off to X-ray."

"What the hell for?"

"A routine chest plate."

"But I had one taken yesterday in the doctor's office and brought it with me."

"Maybe, but it wasn't done here."

You can't beat the system, so down "we" go. During the forty-five minute wait in a draughty corridor it doesn't take long to figure out why hospital costs are skyrocketing. Here the patient may start worrying about that portion of the bill that will have to be paid out of pocket. And promptly too, to avoid being set upon by a professional bill collector who has the unbridled enthusiasm of a lioness on the hunt. By this time the patient also may be getting a little paranoid; things are beginning to have all the earmarks of a communist plot and one wonders whether the hospital is being run for the convenience and comfort of the patients or of the management. Parenthetically, I can sympathize with the hospital administration's plight — they have a job to do, and a tough one. At the same time, think of the poor patient who never wanted to have to go to the hospital in the first place. But, let's go back to the main theme.

The basic elements in the problem of communication between doctor and patient are *sensitivity* and *time*. Fortunately, most doctors are sensitive, some to a greater degree than others. But there are a few who are almost totally lacking in this quality. One of my most shocking experiences occurred while I was travelling abroad. I had a particular interest in a medical school I was visiting, and wanted a general

idea of the kinds of medical problems on the ward of the teaching hospital. It was late in the afternoon, and I asked one of the professors if he would mind taking me on a quick tour of his patients. Somewhat reluctantly, he acquiesced. I was a little upset because he didn't seem to know much about them. Finally he came to a female patient with a tent over the foot of the bed. He didn't say a word to her. He didn't even nod his head or smile at her. He just picked up the sheet, looked at the lower part of her left leg, then turned to me and said, "Oh, bad, very bad. Must lop it off!" and he walked away. Maybe she didn't understand English, then again, maybe she did. In any event, I was stunned, mustered up what I hoped was a comforting nod, and got out of there as fast as I could.

Other than the performance itself, what bothered me was that that man had spent a full year of graduate work in a US teaching hospital where, to the best of my knowledge, this sort of thing just doesn't happen. Perhaps, in this country we're not always as sensitive as we could be, but at least such incidents are not so glaring and crass.

At some point in the kaleidoscopic chain of ward rounds over the years, I started to categorize the people conducting the rounds as either "foot of the bed" or "side of the bed" doctors. There's a lot of literature — mostly in nursing journals, I should add — about the impact of ward rounds on patients. Apparently, it can be positive or negative, depending on a number of factors. I remember being particularly impressed with a study of a series of patients who had been admitted to a hospital with acute coronary disease and suffered a second and fatal attack while in the hospital. One might have expected a random distribution of the fatal episodes throughout the twenty-four hour period, but this was not so. The peak of the episodes occurred before, during, or immediately after ward rounds! This says something too.

Anxiety. Tension. The "side of the bed" doctor can't be expected to change the course of a fatal illness, but he or she certainly makes things easier while the patient is still alive, unlike the "foot of the bed" colleague who, immersed in the academic nuances of "the case," fixes his or her eyes intently on everything and everybody

except the patient. No! No! The good guy is right up there beside the patient grasping a hand or patting a head when appropriate, and most important, making the patient feel that he or she is a human being and the object of genuine concern, not just an impersonal blob of scientific interest. That's empathy; that's also sensitivity.

Although sensitivity is a requisite for satisfactory communication with a patient, it by itself is not enough. This then leads to the other factor — time. Time with the patient. In today's world this is the real problem in medical care, and I haven't the faintest idea how to solve it. I have a hunch that over-reliance on modern technology is one of the causes; furthermore, there are just too many people in the world, and that means an increasing number who need or want medical care, with concomitant demands on the time of the doctor. Regardless of the complexities, however, I'm convinced that all patients, at some particular point during the course of an illness, need from their own doctor more time than they get. If the doctor is sensitive enough to spot these critical moments and to make time available then and there despite other pressures, that's a partial answer. And in going even this far, the doctor can rest assured — it's not "diddling."

# Reunion Reports

## 1924

Ten members of the Class of 1924 and eight of their wives attended our fifty-fifth reunion. Held at the Harvard Club on Friday evening, the cocktail hour and dinner provided a convivial atmosphere for old friends to meet and chat. Those in attendance were: Paul A. Chandler, Robert N. Ganz, Frederic W. Lathrop, Paul F. Orr, George C. Prather, Armand L. Caron, Panos S. Dukakis, John T. Jenkin, Bancroft C. Wheeler, and Hyman L. Kramer.

PAUL A. CHANDLER



## 1929

Forty-three classmates and thirty-four guests registered for the celebration of our fiftieth anniversary. Members of the reunion committee deserve our hearty thanks for arranging this pleasant occasion—Slim McDonald, editor of the class report; Ed Prien, class treasurer; John Adams, arrangements committee; and Roy Mabrey, sponsor of our luncheon at the Country Club.

Among those present were J. Adams, H. Adams, Bright, Dixon, Evans, Farrell, Gayl, Gilman, Goodwin, Gundersen, Hill, Holsclaw, Hurwitz, Jacobson, Jewett, S. Kelley, Loverud, Mabrey, Maggio, McGinn, Noble, Ortiz, Parnell, Prien, Quintilano, Rhodes, Rosenberg, Ross, Sears, Arnold, Cohn, Poindexter, Simon, Spurgeon, Stabler, Twombly, Tanzer, Thorpe, Thompson, Wallace, Watson, and Humphreys.

The anniversary banquet was held on Friday at the downtown Harvard Club, which occupies the top floor at 1 Federal Street. The weather was sparkling clear so that we could enjoy the superb view of the Boston waterfront. Our guest speaker was Perry Culver,



director of alumni relations. In a straightforward manner he told us what is going on at HMS, and assured us that the student unrest of the '60s has subsided, and that the faculty gradually is regaining leadership at the School even though individual grades, and the AOA have been abolished.

Prior to Dr. Culver's talk, Ed Prien,

John White, Vincent Maggio, Hildrus Poindexter, John Adams, and Douglas Holsclaw spoke informally about current medical problems in their respective communities. Some appeared optimistic, while others expressed gloom about the future of medicine. As an extra treat, Sai Chan, guest of Tom Dixon, and former associate of I.M. Pei,



the famous architect, enlightened us about the problems encountered in the design and construction of the new addition to the National Gallery in Washington. A memorable luncheon at the Brookline Country Club on June 2nd was a fitting climax to a very enjoyable anniversary celebration.

SYLVESTER B. KELLEY

## 1934

The forty-fifth reunion was enjoyed by thirty-seven classmates and thirty-two wives. Following the Scientific Symposium, a group of sixty-six met at the beautiful home of Richard Warren in Dedham for cocktails and a buffet supper livened by a wandering minstrel-type accordian player. Dr. and Mrs. William B. Castle, who have joined the class at all its reunion festivities in the past, were here with us again and brightened the evening by their lively remarks; we showed our esteem by presenting Mrs. Castle with a bouquet of roses.

At the annual business meeting, Dr. Carl Walter announced that our class was the leader in donations to the Alumni Fund for the five year period since 1974, with a total of \$88,354.

Shortly thereafter, forty-six of us set out for the Chatham Bars Inn, where a cocktail party followed by dinner were enjoyed. The next morning early golfers, bird watchers and tennis players assembled at 11 am to attend a mini-symposium on a variety of topics. Richard Warren spoke on the care and cultivation of conifers, G. Newton Scatchard discussed the life and times of Chincoteague ponies and birds, David Rutstein spoke on the hereditary aspects of alcoholism and the benefits of wine, and Ben White told interesting tales of his father-in-law, one of our class's honored professors, Dr. Stanley Cobb. John Reidy welcomed those who had come and made some memorial remarks in honor of class members who have died. Sherry, lunch and an afternoon of sociability and sports led up to a dinner dance.

"The Captains and the Kings" (and Queens) began to depart on Sunday morning and after lunch the last had set off toward their native habitats to get rested up for the fiftieth reunion. A great time for all!

JOHN R. GRAHAM



## 1939

Forty-six classmates, almost half of those who remain, with nearly a corresponding number of beautiful wives, gathered for our fortieth. They came from such diverse places as Hawaii, California, Seattle, Florida, Puerto Rico and from many points in between. It was one of our largest and best reunions, marred only by the absence of those who could not attend.

We came on strong at once. Sandy Bill, versatile as ever, moderated with exquisite humor and finesse the Scientific Symposia Thursday morning. On Friday, Guy Hayes, last speaker of the day, poignantly emphasized the importance of taking time to appreciate the patient's anxieties and concerns.

We had a gala buffet party Thursday evening in the Waterhouse (formerly "Faculty") Room of Building A. The space was ample and curiously enough

there was drink to spare, the one indication, perhaps, of our advancing age. Eben Alexander, our distinguished president who has guided, exhorted and stabilized us throughout forty years, gave a charming welcoming talk and introduced another illustrious professor from our ranks, Vincent Dole, who pointed out with wit and humor that we are not so young as we think we are.

On Friday afternoon we drove ourselves to the Chatham Bars Inn. Despite congested highways and the shortage of gasoline no one foundered or was lost. We gathered in Digit Hall at the Inn to the welcoming strains of music from the '30s, provided and arranged by John Brabson, a marvelous introduction to the weekend. We danced to this captivating music till dinner, which was served in the large hall of the Inn, where we were flanked by the congenial classes of 1934 and 1954. After dinner Eben introduced the





two speakers of the evening. First was Jim Bennett who, having transported several people to Chatham by flawlessly driving an unfamiliar and recalcitrant 1971 Volkswagen bus, was virtually panting for a marathon. He gave us a scintillating, fast moving talk with slides and charts that portrayed the ordeals of long distance training and captured the agony of every mile of the 1977 Boston Marathon which he had run in 3 hours and 29 minutes. Jim is trim enough to run it again before our forty-fifth. Kash Mostofi, one of the world's most renowned pathologists, gave a vivid account with slides of his recent trip to Russia where, with intrepid ingenuity, he had ferreted out prominent Russian scientists who could not be carefully concealed by the Soviet State.

Saturday was a gorgeous day for golf, tennis and sightseeing. We had a clambake on the beach at noon and dinner in the main hall in the evening. Before dinner Ted Rulison showed extraordinary pictures of American Samoa and told of the medical efforts there to which he himself has contributed so much. After dinner we saw superb underwater slides of tropical fish off the Samoan coast. We are deeply indebted to these four talented classmates who gave so generously of their time and entertained us so well.

Saturday's final event was an exhilarating ball with excellent music and dancing, culminating at midnight in some fine and very loud choral singing. We parted on Sunday with sadness and with new vigor and new inspiration too. Perhaps as we get older our reunions should occur every two or three years instead of every five and last for an entire week.

ARTHUR S. PIER

## 1944

On Thursday we were treated to a smorgasbord of excellent papers at the Scientific Symposium, delivered by HMS faculty and alumni. Our reunion officially began that evening at 6:30 pm when eighty-one classmates and wives arrived at the thirty-third floor of the State Street Trust Company and enjoyed a convivial cocktail hour and excellent dinner overlooking a panoramic view of Boston Harbour. Most people returned to the Copley to carry on the evening.



On Alumni Day we heard some provocative talks by various members of the reunion classes, including our own Neill Weaver. A buffet luncheon followed and then a hasty departure to Woods Hole in time to catch the ferry to Oak Bluffs and then to Edgartown and the Harborside Inn. We were royally treated, and I believe everyone had an excellent time. Saturday was a sunny, perfect day for sailing, tennis, and exploring the Vineyard and Chapquiddick. Those of us with thinning hair had red pates! Sunday was a leisurely day of more sailing and good conversations.

I would like to thank all the committee members, especially Ernie Kahn and Jim Patterson, the editors of the "Red Book," and our conscientious

treasurer, Keith Merrill, who kept the books. At last report it appears that we are coming out even. And now on to the fortieth!

WILLIAM C. WIGGLESWORTH

## 1949

The thirtieth reunion of the Class of 1949, while not distinguished by the quantity of its participants, was memorable for the quality thereof. Two of our most illustrious classmates, Sam Clark and Alex Rich, made all of us proud with their erudite presentations at the Scientific Symposium. Following that auspicious beginning, '49ers





gathered in the Alexander Parris room beside the Great Dome of Boston's most popular attraction, Quincy Market, for an evening of good food and drink, renewed friendships and shared reminiscences.

We were particularly honored by the presence at our party of an ad hoc honorary member of the Class of 1949, Mark Altschule '32, who confessed that he had, thirty-four years ago, voted against the admission of women to our class—not because of any deep-seated male chauvinism, but because he felt that HMS did not have appropriate plumbing facilities. We who became the first women admitted to Harvard Medical School acknowledged that he was probably right, since the plumbing is still inadequate.

After attending the alumni program we left for Woods Hole, where we took the ferry to Martha's Vineyard. Together with the classes of 1944 and 1959 we spent two delightful days and nights at the Harborside Inn in Edgartown. Saturday was clear and sunny, perfect for sailing, bicycling, and beach-walking. After a delicious shore dinner Saturday night we had laryngeal exercises (?singing) to the accompaniment of Bill Downey's talented piano playing. Sunday morning he had creaking fingers and we all had croaking voices.

DORIS R. BENNETT

## 1954

Sixty-two members of the Class of 1954 and an equal number of consorts and assorted children convened at HMS for the twenty-fifth reunion. After the Scientific Symposium chaired by Frank Austen, featuring Baue on hearts, Rubin on livers, Pearson on spleens, Shore on psyches and Scheibler on politicians, the class gathered at the downtown Harvard Club for dinner. Class President Bob Jones was in charge of the program that featured brief reports on the reunion activities by Milt Alper and on the class gift by Herb Goldings. Dan Federman '53, Dean for Students and Alumni, brought us up to date on the latest developments at the School. A surprise speaker, by popular demand, was Farrok Saidi, fresh from the revolution in Iran. His firsthand account made it clear that he handled those world-shaking events with the same aplomb as he did our four years at HMS.



The next morning Tom O'Brien presided with customary urbanity over the Alumni Day exercises. Norm Trieger, Ed Messner and Nanette Kass Wenger reminisced about our lives as medical students and our activities since then. Later, at the business meeting Herb Goldings reported that our class gift totalled \$12,246, an unusually large amount for a twenty-fifth class.

Friday afternoon we took off for the Chatham Bars Inn for eating, dancing, tennis and walks on Nauset Beach. Jack Vorenberg fell naturally into his old slot as the Bill Veeck of HMS '54 and organized a softball game that faded when someone noticed there was no orthopedic surgeon in attendance. Brad and Eleanor Judd introduced the class to the Shrewsbury bee, chief denizen of their apiary. And Bud Vine

won the Lew Rashin award for the classmate who looked most like himself, circa 1954.

On Sunday morning, as people started to pack up and drift off, Art Garceau and I had a meeting of the minds about the reunion and our class. We decided that the Class of 1954 holds up pretty well as a congenial and interesting bunch of people. Our relationships persist and come to life every five years as if without interruption. That sense of stability, we agreed, means more with time. We both remarked that it's too bad everyone couldn't have been there.

The thirtieth anyone?

MILES F. SHORE



Our twentieth reunion began Thursday evening with sixty classmates and spouses gathering at the Union Club in Boston. A memorable meal arranged by Jack McPeck and Kim McCully helped ease the arduous task of filling in gaps of five to twenty years, depending on when one had last returned to HMS/HSDM. The reunion distance award went to John Urquhart (Palo Alto) with Sam Kaplan (Bellevue, Washington) a close second. Other distance travelers included Kelly Dixon (Greenville, South Carolina), Bert Litwin (Milwaukee), and Art Herbst and Bob Blacklow (Chicago).

On Friday, after a morning of activities at HMS, a smaller band of forty-four dashed to Woods Hole to catch the ferry to Martha's Vineyard and the Harborside Inn in Edgartown. Fingers were crossed and a few prayers said for the weather (memories of rain and more rain in Chatham in 1974 were still with some of us); but the gods were willing, and Saturday was the first of two glorious, sunny days. Classmates scattered in all directions to partake of the island's riches, and '59ers were noted sailing, playing tennis, jogging, cycling to South Beach, not to mention eating and lounging about. Saturday ended on a high note, with everyone convening for evening cocktails at the home of Kitty and Tony Kris, a superb setting, with views of an ocean sunset and Gay Head cliffs in the distance.

Sun-soaked (some of us), a few pounds heavier (most of us), friendships renewed, we made our way back on Sunday to the mainland and reality. Let's do it again.

IRA G. MARKS



## 1964

HMS '64 began its reunion with a cocktail party at the home of Paul and Catherine Bittenweiser. The affair was well attended and provided a grand opportunity to renew friendships. Mini-reunions continued into the evening at various homes and "watering holes." Official activities resumed Friday morning under the tents in the Quadrangle. Many were impressed with the face-lift that has been given Buildings A-E. After the last of the free lunches, we moved on to the Stageneck Inn at York Harbor, Maine for cocktails and a relaxed dinner. The climax of the weekend was a delightful seaside clambake and extended impromptu happy hour on Saturday.

The exchanges were many and varied. Elmer Cranton has resolved the distance crunch of office, home and hospital by becoming a family practitioner in Virginia, and eliminating hospital-based patient care with an office in his home. Bob Northrup told us how one logically evolves from the study of glucose, water, and electrolyte flux across the small intestine mucosa to a career devoted to health care planning and analysis. We were all encouraged and warmed to see the progress that Tony Wattleworth has made in his recovery from a severe cervical spinal cord injury last summer. His spirits are

high and the plans that he and Carol are making are ambitious and exciting.

Many returned with spouses and participated in some part of the reunion activities. Attending were Bittenweiser, Chapin, Chapman, Chylack, Corlette, Cranton, Dean, Dorsey, Glickman, Hartmann, Hoyer, Hurd, Kane, Karchmer, Kim, Latt, Lawrence, Leff, MacGregor, McCarley, Mitchell, Northrup, Peter, Pitt, Rapo, Reynolds, Rhoads, Rosefsky, Rubenstein, Sabin, Seidman, Swarr, Tapper, Wattleworth, Williams, Young. The award for distance traveled was shared by Lowell Young and Don Mitchell, who came from opposite ends of the West Coast, but Lowell won the "circuitous return-home" prize with a stop in Alaska. The major complaints voiced were (1) that no one had aged significantly; (2) that everyone involved wasn't at every event so chances to visit and renew friendships were reduced; and (3) some local classmates didn't participate and thus disappointed their friends from afar. Nevertheless, it was great fun and a suitable warm-up for the next reunion.

A. W. KARCHMER

Prints are available from Hookailo Studios of Photography, Brook House, Brookline, Massachusetts 02146 for \$8 each. Shipping, postage, and tax included.



For members of the Class of 1969 reunion activities began Thursday evening with a cocktail party graciously hosted by George and Barbara Thibault at their Newton home. Except for the mellowing that comes with age, we all seemed much the same as during our days at HMS. We continued our reminiscing Friday at dinner in the Rotunda of the Museum of Fine Arts. The evening was capped by a viewing of slides from our second year show, courtesy of Joe Silvio. The numerous snide remarks accompanying this presentation showed just how little we have changed. Our family picnic on the final day of the reunion was blessed both by lovely June weather and the surprising appearance of Dr. Joseph Gardella who shared in our remembrances. I think that everyone had a thoroughly good time and we all look forward to future reunions.

MERRILL LITEPLO



## 1974

Forty-three classmates and spouses, as well as assorted children, gathered on Saturday afternoon at Dr. Culver's home in Lincoln for our fifth year reunion. We enjoyed the delicious cook-out, warm and sunny weather, vigorous games of volleyball, and congenial atmosphere as old friendships were renewed and, in some instances, new friendships formed.

There was talk of the "good old days," but mostly we chatted about how we had structured our lives in the spheres of medicine, children, and vacations. Don Allegra, currently working for the CDC in New Orleans, came the longest distance. Other dedicated travelers were the Tennenbaums from New York and the Canes from Connecticut. The Boston contingent was well represented, of course. Sina and Tom Najarian came with the most children (three), including our class baby, Nova. Eleanor Hobbs got the award for "most pregnant," expecting twins in July to join two year old Heather.

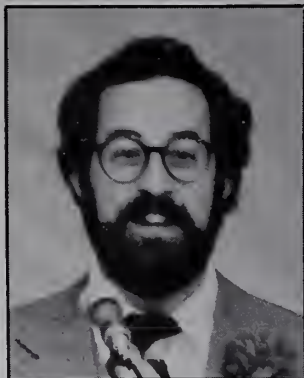
There were genuinely warm feelings as we said our good-byes and began looking forward with some trepidation and much optimism to our tenth reunion.

JANE NEWBURGER



# Class Day 1979

*Jim Kirshenbaum: poignant memories and experiences.*



*David Gordon: Are we going to care about medical students?*



*Liz Kincannon, Sue Witkie: So how do we handle this anxiety?*



*Marlene Krauss: heroics and glamour don't matter very much.*



Whoever first said that it never rains on a Harvard graduation unfortunately omitted Class Day from equal coverage. This year it was cool and overcast, with rain intermittently drenching the proceedings as the graduates, 52 women and 104 men, and their 1800 guests huddled under the protection of their respective tents.

Yet rain, no matter how hard, could not daunt the collective voice of the Class of 1979. Through a variety of modes, seven classmates looked back over four sometimes trying years, "a cataloging of which produces a seemingly endless array of humorous, challenging, consciousness-raising, some would even say poignant memories and experiences forever etched on our minds," according to James Kirshenbaum, Class Day Representative and moderator of the program. And they looked forward to internship with trepidation but also with hope and humour.

"The years have unquestionably affected each of us in personal, special ways," James Kirshenbaum continued in his welcome, although, he noted, they had all had many experiences in common: "We have shared in the exquisite excitement of bringing life to its

first non-aquatic breath, and in the stark, painful inevitability of its death."

David Gordon reminded his classmates that as interns they will also be teachers, and asked them to consider how they will discharge this responsibility. Susan Witkie, Elizabeth Kincannon, and Gerard Aurigemma showed that they had coped with the stresses of medical school by relying upon one another and by frequent laughter. Guest speaker Ned Cassem '66 echoed several of their strategies in explaining the risks and benefits of internship. Marlene Krauss related her media-induced fantasies of the doctor's role, which had been tempered by reality.

Social issues also concerned the Class of 1979: Eve Higginbotham emphasized that minority students in the '70s have had to be constantly vigilant and that efforts in this regard must become more, not less, intense. On behalf of classmates James Distelhorst and Thomas Campbell, Richard Rockefeller spoke of the importance of family practice as a specialty, and of their commitment to it, while deploring its inactive state at the Medical School. Donald Kennedy, former FDA Commissioner and the "outside" in-







*Givers and Receivers: Henry Taylor read the citations as Tom Campbell and Jim Kirshenbaum made the presentations to Drs. Fam and Arky.*

vited guest speaker, dissected the ways in which health care policy is currently formulated. Carrying on a musical tradition begun last year of student as performer, Jill Stein accompanied herself on the guitar, mesmerizing the audience with two ballads she had composed.

As the weather cleared, I. Leon Dogon, D.M.D., associate dean for administration of the Harvard School of Dental Medicine, congratulated the new dentists and physicians, following which Dean Tosteson delivered the valediction and read the Hippocratic Oath. Then the Class of 1979 stood and took as their oath the Declaration of Geneva.

**N**umerous faculty members and administrators helped, in the words of Class Day Representative James Kirshenbaum, "create an atmosphere essential for the acquisition of skills necessary for critical thinking, scientific analysis, and humanitarian, compassionate decision making." Since recognizing all such deserving persons would be impossible, the Class of 1979 singled out those whose influence had touched many.

A certificate of appreciation went to **Thomas Wright**: "One individual to symbolize all those unsung heroes, someone who has shared the rigours of Vanderbilt Hall, someone who has borne the weight of Harvard Medical School bureaucracy patiently."

Preclinical awards were given to four individuals "who still see teaching medical students as their primary profession." **Ronald A. Arky, M.D.** for "organizing our endocrine pathophysiology course with a skill rivaling the physiologic regulation of glucose"; to **Aziza Hanna Soliman-Fam, M.D.** for "conveying an enthusiasm that made anatomy dissection as exciting as unearthing an Egyptian mummy"; to **Edwin J. Furshpan, Ph.D.** (in absentia) for "persevering patiently with us until we finally understood the biochemical details of nerve conduction"; and to **David D. Potter, Ph.D.** for "the clarity with which he translated the esoteric molecular structure of biology into the everyday movement of human muscle."

Seven members of the clinical faculty called to the podium by Thomas Campbell were similarly lauded:

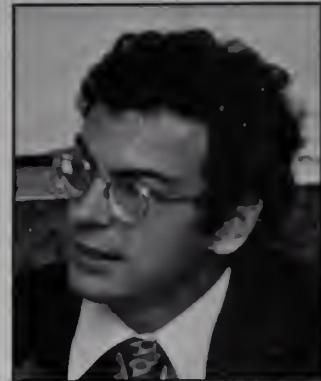
**Ramzi S. Cotran, M.D.**, chief of pathology at the Peter Bent Brigham Hospital, "has devoted time and interest to personally instructing medical students and skillfully making an unusually complex subject more understandable."

**Franklin H. Epstein, M.D.**, chief of medicine at the Beth Israel Hospital, who, despite major clinical and administrative responsibilities, "has exemplified for us the importance of gentleness and humility in the care of patients."

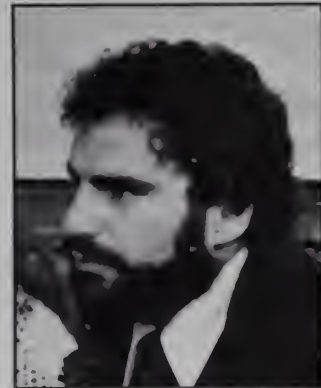
*Eve Higginbotham: minorities and women hold a double duty.*



*Richard Rockefeller: a revitalization of family practice.*



*Gerard Aurigemma: laughter is commonly indicated.*



*Jill Stein: I wish I could hail every sorrow I see.*





*Clinical appreciation: Drs. Epstein, Cotran, Goldman and Hatem (left to right) were among those honored by Tom Campbell (at podium), Henry Taylor and Jim Kirshenbaum on behalf of the class.*

**Harvey Goldman, M.D.**, professor of pathology at the Beth Israel Hospital, whose "sense of humor and vitality has shown us that pathology can be both challenging and exciting."

**Charles J. Hatem '66**, director of medical education at Mt. Auburn Hospital, who has shown "concern and dedication to improving the Introduction to Clinical Medicine and the quality of clinical teaching in general."

**Leston Havens, M.D.**, professor of psychiatry at Massachusetts Mental Health Center, whose "remarkable teaching interviews have helped us discover the surprising subtleties of observation and conversation with patients."

**Frederick Lovejoy, M.D.**, coordinator of the core clinical clerkship at Children's Hospital Medical Center, whose "enthusiasm and excellence in teaching clinical skills and pediatrics has been an inspiration."

**John Stoeckle '47**, director of primary care at the Massachusetts General Hospital, who "by example has demonstrated that it is possible to maintain uniquely personal relationships with patients in a very large and busy teaching hospital."

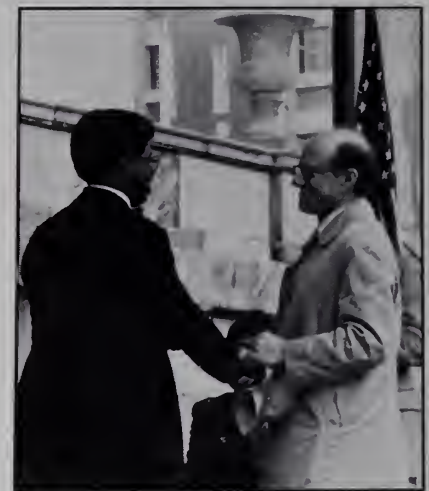
Registrar **Audrey Noreen Koller** and assistant registrar **Dorothy Rackerman** were presented gifts by William Rigby as tokens of thanks and esteem, from still another class that had found that "their efforts on our behalf have always been

marked by fairness, sensibility, and efficiency." More important, he said, has been "their treatment of each of us as individuals with warmth, dignity, and understanding."

**Drs. Leon and Carola Eisenberg** were both recipients of gifts from the class. Leon Eisenberg for demonstrating, in the words of A.J. Rogers, "a deep concern for minority participation in medical education...He has enriched the experiences of all Harvard Medical students by his thrusts for diversity among the student body." Cheryl Warner said of Dean Carola Eisenberg, "In her short time here, she has done much to make students feel that there really is someone to whom they can go for guidance, comfort, encouragement, and support...the Class of 1979 feels fortunate to have benefited from the contribution that she has already made."

One gift of thanks was also a farewell: **June McFee**, who has served as financial aid officer for five years, is returning to Canada to pursue her musical career. Ed Weinberger praised her "not only for what she has done in her official capacity but as a close friend who made Harvard a much more livable and enjoyable place."

A moment of remembrance for deceased classmate Robin Berlin was observed. Ms. Berlin had entered the Medical School with the Class of 1979, then after a short time withdrew and reentered with the Class of 1980.



*Men of distinction: (top) Tom Wright, keeper of student morale, is congratulated by Henry Taylor and (bottom) Leon Eisenberg is lauded by A. J. Rogers for his support of educational pluralism.*

**Nick S. Adzick** was awarded the Richard C. Cabot Prize for the best paper on medical education or medical history for his paper, "Joseph Erlanger, M.D.: Studies on the Etiology of Stokes-Adams Disease."

**Paul R. Billings** received the James Tolbert Shipley Prize for research, the results of which have been published or accepted for publication, for his papers, "Cytotoxic T Lymphocytes Specific for I Region Determinants Do Not Require Interactions with H-2K or D Gene Products," (*Journal of Experimental Medicine* 145:1387-1392, 1977);



"Cytotoxic T Lymphocytes Induced Against Allogeneic I-Region Determinants React with Ia Molecules on Trinitrophenyl-Conjugated Syngeneic Target Cells," (*Journal of Experimental Medicine* 146:623-628, 1977); "Genetic Control of Cytolytic T-Lymphocyte Responses: I. Ir Gene Control of the Specificity of Cytolytic T-Lymphocyte Responses to Trinitrophenyl-Modified Syngeneic Cells," (*Journal of Experimental Medicine* 148:341-351, 1978); and "Genetic Control of Cytolytic T-Lymphocyte Responses: II. The Role of the Host Genotype in Parental  $\rightarrow$  F<sub>1</sub> Radiation Chimeras in the Control of the Specificity of Cytolytic T-Lymphocyte Responses to Trinitrophenyl-Modified Syngeneic Cells," (*Journal of Experimental Medicine* 148:352-359, 1978).

**Samuel W. Casscells, III** won the Leon Resnick Memorial Prize for excellence and accomplishment in research — and also the M.D. degree *magna cum laude* in a special field — for his thesis, "Influence of Alpha- and Beta-Adrenergic Antagonists on the Initiation and Maintenance of Ventricular Fibrillation."

**Dan J. Fintel** was the winner of the Harold Lamport Biomedical Research Prize for the best paper reporting original research in the biomedical sciences — as well as the M.D. degree *magna cum laude* in a special field — for his thesis, "Angiotensin II and Renal Function in Normal Man."

**Thomas J. Kipps** was the recipient of the Henry Asbury Christian Award for notable scholarship in studies or research — and an M.D. degree *magna cum laude* in a special field — for his thesis, "Suppressor T Cell Regulation of Immune Responses Under Ir Gene Control."

**Timothy C. Reynolds** won the Louise B. Carr Prize for excellence in contributing to the betterment of Medical School life.

**Vilma Ruddock** received the Rose Seegal Prize for the best paper on the relation of the medical profession to the community, for her paper, "Health Care Delivery in the Rural Caribbean with Special Reference to St. Thomas, Jamaica, West Indies."

**Susan M. Witkie** was awarded the Dr. Sirgay Sanger Award for excellence and accomplishment in research, clinical investigation or scholarship in psychiatry for her paper, "Obesity and



Body Image: An Experimental Approach to the Assessment of Body Image and Its Disturbance in Obese Adolescents — Implications for Its Application in the Assessment/Suggested Treatment of All Obesity."

Along with Drs. Casscells, Fintel, and Kipps, another member of the class received his degree *magna cum laude* in a special field:

**Louis L. Safranek, III**, for his thesis, "Hormonal Regulation of Melanization in the Tobacco Hornworm, *MAN-DUCA SEXTA*."

Nine graduates were awarded the M.D. degree *cum laude* in a special field:

**Douglas V. Faller**, for his thesis, "Neutral Amino Acids in the Brain: Changes in Response to Food Ingestion";

**David Gordon**, for his thesis, "Intimal Alterations of the Rat Aorta Produced by Stress: Insights into the Pathogenesis of Stress-aggravated Atherosclerosis";

**Glenn M. La Muraglia**, for his thesis, "Breast Cancer: Investigations for the Development of Primary Cell Cultures and the Establishment of *in vitro* Chemotherapeutic Assays";

**Arthur D. Resnick**, for his thesis, "Exercise-induced Asthma: Heat Exchange Hypothesis and a critical Assessment of the Effects of Hyperoxia";

**James M. Rippe**, for his thesis, "Hemodynamic Studies in the Trained Racing Greyhound: A Model of the Development, Functional Conse-

quences and Regression of Exercise-induced Cardiac Hypertrophy";

**Joseph A. Sorge**, for his thesis, "Immunogenetics of the Male Antigen and Its Role in Sex Determination";

**Vikas P. Sukhatme**, for his thesis, "Varying Cell Shape in Tissue Culture by Changing Substratum Surface Charge";

**Bradford B. Walters**, for his thesis, "The Effects of Cyclic AMP on the Phosphorylation of Synaptosomal Plasma Membranes and Postsynaptic Junctional Lattices"; and

**Susan M. Witkie**, for her thesis, "Obesity and Body Image: An Experimental Approach to the Assessment of Body Image and Its Disturbance in Obese Adolescents — Implications for Its Application in the Assessment/Suggested Treatment of All Obesity."

# Valediction

by Dean Daniel C. Tosteson

**M**embers of the graduating class and your families (parents, spouses and children), Dean Federman, Dean Eisenberg, Dr. Cassem, Dr. Kennedy, I thank all of you for making this day possible. On behalf of the Faculty of Medicine of Harvard University, I express our gratitude to the persons in the Class of 1979 for choosing to join us, for contributing your imagination and work to this institution. Your learning here enriches us all. I want particularly to thank your families and friends whose sacrifices have made it possible for you to be in a position to make this day.

I want to share with you some reflections on belief and diversity in the living of physicians. To some extent, these thoughts arose from hearing of your concerns about the oaths

that we will soon read. Jim Kirshenbaum shared with me some of the questions that were raised in your discussion of oaths. I respect and applaud that you take seriously what you swear. It correctly acknowledges that belief is the basis for action. You have again discovered that you, we, differ in our beliefs. Both this diversity of beliefs and the beliefs themselves are of great importance to those who will practice medicine.

Last week Dr. Carleton Chapman, a member of the Class of 1941 and currently president of the Commonwealth Fund, delivered the 1979 George W. Gay lecture in medical ethics. He pointed out that the ethical codes adopted by physicians from Hippocrates on have been concerned with many issues other than ethics, for example, with the organization and

techniques of medical practice. He urged the medical profession to reform its ethical code to address the fundamental decisions between right and wrong that must often be made by physicians. He urged that such a code be based on the axiom that each physician place the welfare of the patient above all other considerations.

This proposition is, of course, the starting point for an ethics of medicine. Most ethical problems arise when there are differences of opinion about what constitutes the welfare of the patient. If the patient and his or her parents, spouse, friends or physician have different views, what is the right view and how should a decision be reached? You will have many opportunities to work out such problems. Your discussion about the oath is a case in point.





Diversity of beliefs has been a continuing theme in the history of the United States of America. From its beginning, many persons from all parts of the world have come here in search of a place where they could hold and express their different beliefs. The enabling documents of governance of the country assure religious freedom to individuals and insist upon separation of church and state. In America, we honor the idea that what I believe is my business. The motto of the state of Massachusetts is "don't tread on me." This freedom imposes on each individual the responsibility to identify and hold to the values that guide his or her living and to respect the right of each other to choose and hold his or her beliefs. To accept this responsibility is the primary act of faith. It creates both the need and the possibility to work toward the resolution of conflicts among differing beliefs.

In his elegant address "On Protest and Affirmation" to the class that graduated from the Medical School in 1972, Erik Erikson developed the point that fidelity to some set of beliefs is the basis for a sense of personal identity. He analyzed the concern of that class about the Hippocratic oath as a professional identity crisis. In modern America, where the structure of belief is left so much to each individual it is not surprising that young physicians, among others, have difficulty finding a professional, indeed a personal, identity.

I recall listening to a lecture by Robert Frost when I was a student at Harvard College. He talked about the difference between internal and external discipline. He maintained that inner commitment usually involves a response to external circumstances. In later writings, he made the point by noting the constant symbol in poetry. He likened the making of a poem to all forms of living. The first lines come apparently spontaneously to the mind of the poet. But then the subject, meter, rhythm and rhyme are set and the poem must be completed within those constraints. The quality of the poem depends not only on the first inspiration but also on its subsequent disciplined elaboration. The poet must accept the conditions of the beginning and find the inner belief and strength to work the problem.



**"You must make the effort to find the right answers to the ethical as well as diagnostic and therapeutic problems that you will face."**

I believe that these reflections have meaning for your lives in medicine. You are beginning. Already you have made some choices. Soon you will make more that will set the conditions for your professional lives. Your effectiveness at whatever you choose to do will depend on how you work the consequences of your beginning. You must make the effort to find the right answers to the ethical as well as the diagnostic and therapeutic problems that you will face. To make that hard effort, you must first want to define the problems, to find the answers, to learn. Such desire is a form of what I have called the primary belief and Erikson calls a sense of identity, a belief that you may or may not wish to express in an oath. You'd better believe, corny but true. Find your belief and honor it by continuing to learn in medicine.

These concerns about belief and diversity of beliefs have preoccupied physicians throughout history. I presume on you because I want to express my pride at being part of that great tradition. Theodore Roosevelt said that there are two kinds of persons, those who view with alarm and those who point with pride. We live in a time when it is important and right

for all of us who have the good fortune to be members of the community of physicians to point with pride not only at our history and tradition but also toward the promise of medicine in the future.

Dynamism in all of the branches of inquiry that bear on medicine, in the natural sciences, in the social sciences, in the humanities, in the organization and practice of clinical medicine, make me confident that the year 2000 and beyond will reveal a medicine of power and subtlety now difficult to imagine. But the relation between medicine and philosophy will not change.

The physician will still struggle to bring the wisdom of the ages to the care of a patient in a complex, ambiguous and always new situation. Learning built on the belief that we can do something about the problems that limit our living will continue to be the basis for medicine. The lines inscribed on one of the buildings at the Harvard Medical School, which I first read as a student thirty years ago and still savor from time to time, will remain as valid as when they were written by Hippocrates. "Life is short and the art long, occasion instant, experiment perilous decision difficult."



Dr. Cassem

# Internship, Liberty, Death and Other Choices

by Ned Cassem

## How to survive life in the hospital

Prior to receiving his medical degree from Harvard in 1966, Ned Cassem earned two masters degrees in philosophy and psychology from St. Louis University. During his psychiatry training, he worked towards a bachelor of divinity degree, which he received from Western College in Cambridge in 1969. The following year he was ordained a Jesuit priest. In his seven years on the faculty, Dr. Cassem has been director of residency training in psychiatry at the MGH and most recently chief of the consultation-liaison service. He is now associate professor of psychiatry and chairman of the hospital's optimum care committee.

In introducing Dr. Cassem, Dan Rome '79 commented on his reputation among the student body. "There are certain names at the Medical School that seem to have a life of their own and you can't be here long before you hear them spoken repeatedly. If you're lucky, at some point during the four years here you meet the people behind those names. Ned Cassem is one. Until two months ago, when Jim [Kirshenbaum] asked me to introduce Dr. Cassem, I had never met him. Since then I've had the special pleasure of hearing him speak and also of visiting and chatting with him. In fact, Jim's persistence gave me the perfect excuse to begin to get to know a truly remarkable person. I can say that in four years I have never heard a disparaging word about this person."

Fifteen years of immersion in intensive care cardiac and cancer units, helping patients and staff confront death, no doubt made me an obvious choice to address a group on the threshold of internship. I hasten to assure you that this represents the sympathy, not the wishes, the faculty have for you (fourth year show notwithstanding). Moreover, fear that undue levity might taint this solemn occasion prompts me to return to the sober if not ominous implications of that March event known (by one of the most presumptuous epithets of our time) as the "Match." I realize that all of you signed up for internship and cannot back out — or so you're told. But did you ever sign, let alone see, an informed consent? Has your internship program been approved by a human studies committee? (Naturally I hope none of you is so crass as even to consider an internship that *could* pass a human studies committee.) Nevertheless, mindful of lofty ethical principles and fearful of future charges against HMS for malpractice or criminal negligence, I come here before you to read you the risks and benefits of the internship year.

First the risks. Since the risks of internship cannot be computed even by the MIT computers, I have chosen in the time allotted to me, ten common risks, purely at random. These represent conditions, states or experiences for which any term worthy of the name is a high risk (and, I might add, any physician).

**Risk No. 1. Acute and Chronic Delirium.** Sleep deprived for forty hours or more (a number chosen be-

cause it represents a week's work for other people), physically exhausted, toxic from caffeine, covered with a thin hematogenous and/or fecal veneer, you may find yourself disoriented to time and place, mumbling and writing incoherent gibberish, dispossessed of recent memory, and, though probably still able to feed and relieve yourself, beset by growing paranoia about the malevolent intentions of patients, families and co-workers toward you. The only thing that can reverse this condition other than sleep (which is neither possible nor condoned) is an acute emergency — and that is the last thing you want.

Having reached this disoriented state you will have accomplished a remarkable feat, sometimes known as the Ponce de Leon substitution, that is, you, in the bloom of youth, have become a gomer. This confers on you a degree of immortality for, as you know, according to House of God Rule 1. Gomers Don't Die. (At this point I'd like to ask spouses, families and friends of graduates to keep them carefully propped in their chairs because of Rule 2. Gomers Go to Ground.)

**Risk No. 2 Shattered Self-Esteem.** Soon into your internship, far behind on the scut sheet, no cures accomplished, woefully inept at buffing and turfing, your present memory impairment thwarting every effort to recite the most recent JCI references on rounds, your self-esteem may go out on wildcat strike. Then you will realize that your progress through the grade-free HMS curriculum ended in an ersatz degree. You may pray for some serious illness so you can retire honor-



ably from the internship. Basically you realize that you were never meant to be a physician. At this point, you are more susceptible to Risks 3-10.

**Risk No. 3. Depression.** Yes, deep-down, bottom-of-the-well, no-hope, what's-the-use depression. If you are a woman physician you will be more susceptible to this risk; in fact, a recent study in the *American Journal of Psychiatry* estimated that sixty-five percent of American women physicians have primary affective disorders. (Pitts et al, 136:694, 1979) (I would now list the research diagnostic criteria for this condition but so many of you may already qualify that you would be only more susceptible to Risk 4.)

**Risk No. 4. Suicidal Ideation.** Under extreme circumstances, death, sometimes known as Patrick Henry's second choice, may seem to you an acceptable or even attractive alternative. When you've had 9 admissions, are 1 work-up, 5 admission and 32 progress notes behind, face 7 fever work-ups, 3 re-start IV's, 2 disimpactions, and a Foley catheter insertion (on yourself), have a cold, headache and backache and are oriented times 2, which would you rather have: a 10th admission or an intravenous bolus of KCL?

Though I joke about it, it is sobering to reflect that it takes almost the whole of your class to replace those physicians in the United States who last year took their own lives. Please understand that thoughts of suicide are quite human and common to people under stress. When I found out I had to give this talk I thought of committing suicide, but with my luck it'd probably be a temporary solution.

**Risk No. 5. Marital Disaster.** Divorce is a hazard more common to physicians' than to others' marriages. The internship schedule, after all, is hardly calculated to promote marital bliss, especially when one sends off a physician spouse to the hospital and gets back a gomer. Moreover, due to Risks 1-4, especially when self-esteem has vanished, the tern may, out of anxiety or loneliness or both, experience the volcanic return of adolescent lust and/or the need to be held. Though justified by some as intensive care, the instant affairs born of such needs further threaten a marriage. Often, however, you will be protected from yielding to these temptations by sheer fatigue. But, even when you do get a

chance to go home, your family is usually so mad they're not speaking to you anyway.

**Risk No. 6. Obesity.** No data exist to document this sure-fire hazard of internship because the hospital scales are not adequate for measurements of this magnitude. However, because food is love it can help offset Risk 5.

**Risks Nos. 7 and 8. Alcohol and Drug Abuse.** With the M.D. degree is conferred the statistical right to a high risk of alcoholism and drug abuse. Besides the one class required to replace the doctors who have killed themselves, five more graduating classes are needed to replace the doctors who died last year from alcoholism and drug abuse. Our ready access and high stress make us susceptible. And if you're a tern — exhausted, overwhelmed, intermittently gomerized, paranoid, surrounded by vomitus, excreta, blood and death (to quote a recent Quadrangle production), the bottle may seem like the only friend you can trust.

**Risk No. 9. Disillusionment with the Senior Staff.** We, your clinical faculty, may seem ideal and solid to you now, but when you move into the trenches alongside us as terns, the Twilight of the Idols begins. Our infantile tantrums, neuroses, unbridled narcissism, petty jealousies, delusions of academic advancement, disastrous doctor-patient relationships — not to mention the full-blown appearances of Risks 1-8 — will convince you that getting today's diploma was a mistake. But please know something: we call these behaviors coping with stress, even though we realize they add to yours. (Speaking of neurosis, if, unable through neurotic fear to continue this talk I collapse, I beg you to recall two things: 1. Gomers Go to Ground 2. Please be guided in your resuscitation efforts by my Medic Alert bracelet, which reads "Munchausen Syndrome.")

**Risk No. 10. Chronic Rage and Hatred.** I know no real intern who has not on occasion been consumed with fire-breathing, retaliatory hatred for his or her patients. This experience is one which the lay public, your friends, your parents, your medical students, perhaps even your spouses will never comprehend. Mind you I am not talking about those patients who work intensely, doggedly and ingeniously to

earn your hatred. I refer to ordinary innocent victims of illness. The key to understanding this phenomenon is that impossible demands generate resentment. Your demands come from within and without: within because your conscience demands that you be devoted and tireless in meeting your oath to help people; without because the illnesses are overwhelmingly tragic and their victims plead for help. You're a sitting duck.

Suppose that still oriented times 2, finishing your 9th work-up while anticipating the 5 remaining admission and 32 progress notes, 7 fever work-ups, 3 re-start IV's, 2 disimpactions and 1 Foley insertion, you are paged and told by that EW sieve that your 10th admission, an intoxicated alcoholic with bleeding esophageal varices, early DT's and possible acute abdomen is all yours. Is he a person? Of course, but the patient is also defined by what his illness does to you: this man is not a patient, nor a "case," nor a "bounce," nor a "dump" — this man is a "hit," and you have been shot out of the water. In fact, the motto of the outside world is: Never Leave a Tern Unstoned. Resentment, hatred, rage are only natural reactions to being hit from all sides. With your diplomas each of you will receive a T-shirt with a bull's eye on it. Wear it proudly.

These are only ten of the risks you will face by being a doctor.

And now for the benefits. First the bad news is that the benefits are identical to the risks. The good news is that this cuts my talk in half, thereby calming the number one terror in all doctors' lives — that someone will waste their time.

How can I be so sure you will survive the risks to collect the benefits? Because you are "supercopers." E. James Anthony and Cynthia Janes of Washington University of St. Louis, studying "superkids" who achieved despite overwhelming deprivations, used this model for children under stress: "There are three dolls. One is made of glass, the second of plastic, and the third of steel. They are each hit by a hammer. The first shatters, the second is bent and scarred, but the third gives off a fine metallic sound." In the coming year, I assure you that fine sound will be deafening.

You can expect, stress notwithstanding, greater learning than in



any year so far, a new sense of mastery and self-confidence, multiple clinical skills, many unforgettable people and experiences. But learn your limits and try to live as close to them as you can comfortably tolerate.

1. Read the signal lights on your own psychic instrument panel: hate, tilt, amnesia, aphasia, gastritis, verbal incontinence, migraine, and so forth.
2. When these warning lights go on, you are being hit (now you know how your patients feel) — then it's first things first. Get the work done; go on automatic; shut off feeling; just make it; last to the nearest exit, i.e., time off.
3. When you are hit, holler, even though you may have to save it up. To insure this you need your peer group. Stick together. Loners get hit harder. Women take heed, you are at higher risk. You have full complaining rights with the same full vocabulary. The group should be a good in-house Paranoid Club; let no one hear you except those who understand. Remember you are not in a club to change anything, you are there to complain. Do it creatively. Imaginary retaliation is better than none. Finally, when you've been especially creative, for instance you've come up with a Turkey Scale for Private Attendings, keep it anonymous.
4. Guard your time. You will never have enough of it again. You must claim enough for yourself and use it well.
5. Always fight down your grandiosity. You can (?) learn everything known about illness — do it with rel-

ish but learn to tolerate uncertainty and the fallibility of your clinical judgments, and remain more impressed by the mysteries and uniqueness of your patients than by your own expertise. You are not God.

Learn to be grateful when you've been able to help someone even a little.

## The Physician, the FDA and the Well-Balanced Aphorism

by Donald Kennedy

### Looking beyond the prisms of science and economics for health policy

When I was appointed Commissioner of the Food and Drug Administration two years ago one of the public interest organizations, the Health Research Group, voiced its approval because I did not have an M.D. and was therefore outside the dangerous mainstream of American medicine. I take this invitation as a sign of forgiveness and I plan to demonstrate my gratitude by quoting Hippocrates. The text is his first aphorism, which reads

Don't forget that behind your noble and committed selves are hearts, and there is no finer part of you. So give yourself a break. Hang on your office wall that lofty description of the physician's task:

*To cure sometimes  
To relieve often,  
To comfort always.*

But on the opposite side write Cassem's Perverse Laws for physician sanity:

*Run away sometimes,  
Hate often,  
Complain constantly.*

And ham it up a bit so your fellow doctors get vicarious relief.

If you respect your own limits and vulnerabilities, you'll be freer to enjoy the stresses of medicine and treasure the experiences you'll share with your patients.

I want to thank specifically those of you who sieved me up to this podium, and all of you who have buffed me up with your kind attention, so I can now be turfed back to the speakers' row. Congratulations, Class of '79, we're proud of your partnership with us.

so well that it surely was not written by committee: "Life is short and the art long, occasion instant, experiment perilous, decision difficult. The physician," Hippocrates then goes on to say, remarkably, "must not only be prepared to do what is right himself" (Hippocrates was not prescient, whatever else he was), "but also to make the patient, the attendants and the externals cooperate."

This aphorism is worth looking at for its balance as well as its fine style.



The first part advises the physician of the need to be modest in facing the incredible endemic messiness in life; the second part dissolves that modesty promptly and we see the physician transformed into the role of super-doc, capable of seizing oftentimes highly intractable persons and circumstances and dragooning all of them into cooperation. One suspects that this portion of the aphorism actually reveals Hippocrates not as a moralist or supportive therapist but rather as a sardonic humorist, whispering to himself, "lots of luck," as he wrote the final word, "cooperate."

Instead of introducing you to one of the externals that you will encounter as you take those first few strokes into the dangerous mainstream of American medicine — government regulation — I want to concentrate on a certain polarity that can be inferred from this aphorism. The elements of experience, wisdom, value and all those qualitative features we sum up as art; the contrasting universe contains logic, purpose, and all those precise manipulations that col-

lectively we call science. My purpose in emphasizing this contrast is to try to make the case that in public health policy, we are in serious danger of blurring the distinction because we are increasingly trying to make the precision tools — in this case, science and economics — construct our value judgments for us.

It can be argued that the nature of this mistake relates to the enlightenment view so prominent in our national beginnings, in which the logic and science of the machine was viewed as a model for the conduct of government and for the management of human institutions. The clockmaker as deity, a concept of which Jefferson was fond, found its way into the Declaration of Independence, with its references to the laws of nature and of nature's God. It is with us still, even among those who should know better, when one hears the phrase "the machinery of government." This enlightenment affection for machinery and clockwork suggests that perhaps we can substitute for that chaotic, unscientific and far from automated

tion began life as a kind of police authority on the prowl for outrageous technological dreck in the market place. Later on it became a kind of contraceptive device devoted to evaluating products before they got to the market place, filtering out what was not supposed to be there and allowing the good and the pure in. And as that happened, the scientific capability of the FDA and related agencies got better. One dared to hope that ultimately we would have our clockwork, we would have a level of scientific precision that left every decision unarguable, every scientific assessment clean, and therefore every regulatory choice one that obtained consensus quickly. What was forgotten, of course, is that there are still unanswered questions. What does it mean, for example, to be able to compare health risks associated with toxic substances in people whose situations differ? In short, the scientific accuracy with which we measure the hazards of chemicals in the workplace or in the environment may simply allow us to make increasingly precise social mistakes.

Nowadays the trend is to enlist science, along with economics, in challenges to health and safety regulations. During the Occupational Safety and Health Administration hearings held last year to develop a policy for occupational carcinogens, those of us who served as witnesses were repeatedly asked by industry lawyers what we thought about the relative hazards of workplace toxin  $x$  and, for example, cigarette smoking. We were then led helpfully into a discussion about the cost-effectiveness of limiting the one risk as opposed to the other.

Such maneuvers will become more commonplace. Cancer risks associated with smoking and diet will be emphasized, while those linked to the environment and industry will be minimized. The relative vulnerability of persons with particular genotypes will be pointed out and it will be suggested gently that these persons should avoid employment or exposures of certain kinds where the risks are judged to be especially high. We may hope that these proposals will be a little more subtle than the idea that older men should be peach-pickers because they will not mind being sterilized by the pesticides normally

*Donald Kennedy stepped down from his position as Commissioner of the Food and Drug Administration on June 30th, to assume the office of vice-president and provost at Stanford University. He served there as a faculty member from 1960 through 1976, and from 1965-1972 chaired the department of biological sciences. Prior to heading the FDA, Dr. Kennedy, a neurophysiologist, held the Benjamin Scott Crocker Professorship in Human Biology and directed the human biology program at Stanford.*

*Earl Steinberg '79 described Dr. Kennedy as "a man who has distinguished himself as a gifted scientist and an insightful policymaker. Historically, our profession has reacted antagonistically to government intervention in the practice of medicine. Today, however, we must accept the fact that the government will be making decisions affecting our profession whether or not we choose to participate in the decision making process. If these decisions are to be sensible, however, government officials, physicians and scientists must function as colleagues, not adversaries. During his two year tenure in Washington, Commissioner Kennedy has revitalized the FDA and has earned the respect of both the medical profession and his government colleagues."*



*Dr. Kennedy*

business — the political art — some urgent simplifying theme. For contemporary health policymakers, the themes of science and economics are currently favored to regiment the endemic messiness of life.

There is always the urge to do more with science than may be possible. The Food and Drug Administra-

sprayed on peaches. This effort to redirect the emphasis on chemical carcinogen policy to the characteristics of individuals and away from the characteristics of the society and its institutions is, I think, a good example of mindless reliance on inadequate clockwork.

It cannot be denied that much of the cancer burden in this country is in some sense self-inflicted and that we ought to do something about it; but to suggest that the government ought to do that instead of playing its regulatory role in restricting occupational and environmental hazards, even when the former is more cost-effective, is to blame the victim. Furthermore, our society prizes freedom from social interference. We don't regulate smoking. We don't prescribe dietary habits. Even if it could be shown that lack of exercise is the most serious of all cardiovascular risk factors, the government is not likely to mandate compulsory morning calisthenics. The only regimes to dare attempt such measures are the directorates of summer camps and quite possibly the late and unlamented government of Pol Pot in Cambodia.

What the government does regulate are involuntarily assumed hazards that arise as a consequence of private activity, but not because the current method is the most costly or a carcinogen the most potent. We regulate because we think that the individual so situated deserves the protection of the government. The imperishability of many synthetic organic chemicals, the twenty year latency of many cancers, and other deleterious outcomes yet to be identified have totally devastated the capacity of the judicial system to play its traditional role of internalizing those costs through tort claims. The government, therefore, should not be made to be less aggressive in this area just because somebody can show that larger hazards are voluntarily assumed. Should someone be allowed to poison me because I happen to like to ski fast? It doesn't make any sense. We must regulate the occult risks, the ones that people are exposed to involuntarily, regardless of their relative magnitude, precisely because they are not avoidable through voluntary action.

The second great hope of the clockwork believers these days lies in cost-benefit analysis. This methodol-

ogy has a certain surface appeal alike the notion that the earth is flat, but its defect is a blindness to distributional effects. It was inequities in distributional effects that gave rise to health regulation in the first place. The most devout of all believers in clockwork, Adam Smith, failed to see that the "invisible hand" could not ensure that the people who reaped the benefits also always paid the cost. Developing clean legal devices for cost internalization, for example — such as the marvelously simple law in an Eastern European nation that every factory located on a river must have its intake downstream from its outfall — is not easy. Yet most regulation in the health and environment area has exactly that purpose even though it may lack that elegance of solution.

Cost-benefit analysis employs scientific methods, but the mistakes made in its name are neither economic nor scientific. The errors have to do with much more important matters — with the basic assumptions about fairness and social justice that govern or ought to govern the way we run our society. The failure of cost-benefit analysis is that the numbers often seize the values and not the other way around. Cost-benefit analysis, risk assessment and similar kinds of studies can help clarify questions such as how much does it cost? and even, who benefits? But it cannot tell us who should pay.

Scientists who look at how values have shaped our basic food and drug laws, for example, might conclude, as did a recent study committee of the National Academy of Sciences that "the statutory categorization of foods and food additives currently is confusing, cumbersome and not always clearly related to risks." Just so; there are other considerations as important as the risks themselves, such as whether they are voluntarily assumed, whether there are benefits to be had, and whether those benefits are symmetrically distributed. Admirably, indeed, artistically, in the sense that Hippocrates used the word, the Congress has translated into law a complex and ambivalent set of social values. Laws are surely complex, but they have to be.

We often overlook the fact that there are many pieces of truth in a society as complex as our own and that

the place where all these fragments come together is the Congress. In devising a health regulatory strategy, the essential problems turn out to be those of policy and policy answers have to be produced by the Congress. To grant regulatory agencies blanket authority for balancing risks against benefits and assessing quantitative risks, disregarding the situations of the risk takers, would be a dreadful mistake in public policy. Deciding these issues is a fundamental task that belongs to all of society and consequently must remain a prerogative of Congress.

Health and safety regulations did not fall from the sky nor were they invented to annoy physicians and dentists or to wreck the economy. They developed as people became more conscious that there are public costs associated with private activity — costs that are assumed involuntarily without knowledge, without compensation — through receiving a share of the benefits. The government protects citizens from those external costs by the application of some of the social principles that I mentioned earlier — principles that are almost never stated and that cannot be produced by clockwork no matter how cleverly contrived, and in which all of science, all of economics, and all of the calculations of risk and value play essentially a supporting and never a determining role.

The system of hazard regulation in this country strikes many as irrational. But as I have tried to point out; it does have a rationale if one evaluates decisions on the basis of social value and purpose rather than as dictated by economics and science. The message that I would like to convey to you is that you remember, when assessing public policy, that life is short and the art long, occasion instant, experiment perilous, decision difficult. More than anything else, I hope that you will believe that the intelligent structuring of such policy is a significant obligation worth the same kind of attention you will bring to the art Hippocrates had in mind. In a way, perhaps, it is a method for enabling you to help more patients than you can possibly see.





David Gordon

## Our Role in Medical Education

As members of the leading medical school in the country, we have much of which to be proud. We have one of the most diverse patient populations, a contingent of outstanding researchers, and (if we may say so) some of the brightest students in the country! But what of our education? After all, teaching and learning are what a school should be about. Shouldn't any excellent school always be questioning and evaluating its own educational system, with an eye toward continuous improvement?

There is no question that we have learned a great deal, but it is very important for us to spend some time in reflecting on the quality of our education. As one example, how many of us have been *examined* on our ability to perform cardiopulmonary resuscitation when someone's heart stops? Shouldn't this be part of the M.D. degree, not only because one month

from now we will be the people primarily responsible for such patients' care, but also because we should not feel incompetent in a public place when someone asks "Is there a doctor in the house?" This is not to criticize our learning about rare diseases such as pheochromocytoma, because a disease is neither rare to the patient who has it, nor to the house officer who manages that patient's care.

Let us take a long, hard look at our own education; first, because if there are defects, we're no longer students and now largely have to teach ourselves, and second, because in addition to our patients, we will also be responsible for the education and evaluation of medical students. We have only to look back to our own rotations — and to how important our course evaluations were in our applications to residency programs — to realize how serious a matter this is. If

we as students found our own education lacking, do we now as instructors propose to continue the same faults, or to struggle to make changes for the better?

Will we expect students to already know most things about a particular aspect of medicine, praising those who regurgitate the facts learned by rote, while blaming and ridiculing others who don't know the answers? How long will we spend openly wondering why a student doesn't know something (and in some cases even questioning the validity of his or her admission to medical school) before getting down to the business of teaching? Will we be quick to call a question "stupid," and thereby inhibit further questions? Or will we realize that by definition students are entitled to be ignorant of some things, and that if they are paying tuition, they are also entitled to be taught.

Will we require automatic night call duty for each student because "that's the system" or "that's what we had to go through?" Will we ask a student to lose sleep at night, drawing blood tests and doing EKG's, so that he or she falls asleep in the next day's teaching conferences? Or will we stop

to realize that this may not be the best way for anybody, including house officers, to learn.

In the skewed environment of overworked interns and residents, where scut work occupies an inordinate part of our day, will we become angry at the student who goes off to the library to read about his cases rather than stay around to learn "real medicine" on the ward? Will we grumble about how long a student takes to work-up a patient, and how verbose and irrelevant the chart note is, or will we mature as instructors and teach the student, so that the process does not take so long, and the notes will be succinct and complete.

Finally will we as interns and residents assume that students have learned most of what our rotation has to offer, or will we continually check to make sure they are indeed learning as much as possible, well before evaluation time comes. It will be up to us to see if students actually know how to diagnose and manage hyperparathyroidism and peptic ulcer disease, before sending them off to the library to find out whether or not hyperparathyroid patients have a significantly higher incidence of peptic ulcer disease.

In short, are we going to care about the medical students under our direction? Certainly medical students are not children, but if we care we will not use this as an excuse to leave them without direction and teaching, as often we may have been left. If we care, then we will know not to expect teaching always to be an easy task, even with students who are totally interested. We will accept the challenge of occasionally arguing and struggling with them in the learning process; we will strive to make every student an excellent student, and be concerned about anyone under our direction who fails or does poorly. If we care about medical education, then we will study the faults in the whole medical education system, and encourage and support students and others in their efforts to correct them. Finally if we care about the quality of patient care, then we will strive not only to do our best by our patients, but also to teach our best, realizing that if we don't care about future doctors, it will be hard in turn to teach those in our charge to care about others.

Susan M. Witkie and Elizabeth A. Kincannon

## Angst in Medical Education or Fear and Loathing at HMS

**Sue:** "Normal anxiety is a biologically protective symptom: it is an unpleasant feeling of apprehension accompanied by uncomfortable bodily sensation. (**Liz** — Oh, my stomach hurts.) It is like fear except that fear is associated with an immediate specific, external threat which is non-conflictual. (**Liz** — I think I may be sick.) In anxiety by contrast, the threat is future (**Liz** — My heart's beating too fast.) . . . rather vague (**Liz** — I'm going to die.) . . . and often internal and conflicted." — Definition of "anxiety" by Dr. Fred Guggenheim, Massachusetts General Hospital department of psychiatry.

**Liz:** They told us we'd experience anxiety in medical school. But they said, "Don't worry. We know how to help you with this problem. Just go and talk to someone at the Health Service."

**Sue:** That didn't quite work.

**Liz:** Work? That made it worse. How would *you* like to explain to a Medical School official that your lousy sex life has nothing to do with the fact that you just flunked your micro and anatomy exams?

**Sue:** We're not suggesting that anxiety is *new* in medical school, it's just that more people are cracking up and dropping out (*Liz whispers to Sue*) . . . that is, are experiencing psychoses and taking leaves of absence for research. And finally, some people are looking into what's behind it all. I could give you statistics. In ancient Babylonian medical schools, for example . . .

**Liz:** (*interrupting*) That's precisely the sort of thing that provokes anxiety. Everyone pretends to be the suave intellectual, always demonstrating every bit of the limited knowledge they do have.

**Sue:** Knowledge? You can always bullshit information. It wasn't easy coming up with the seventh Jones criteria for rheumatoid arthritis, but I

did it. What is anxiety provoking is the whole social issue of dealing with human beings.

**Liz:** Yeh. Most med students have spent their entire life being asocial bores in the name of premed.

**Sue:** Now we finally can relax and be normal. But we have to decide if it's better to relate to non-medical people with whom we have nothing to talk about or to date medical people whom we're afraid know more than we do.

**Liz:** I don't know about that. I cooked supper for this nice guy last week, a lawyer. It was great. I dissected the turkey's heart for him and he said he really liked the cute little papillary muscles.

**Sue:** It's too bad we're so locked into the medical model.

**Liz:** I used to walk into the dorm at 3 am after a Saturday night out on the town and there would be at least fourteen lights on — people up studying.

**Sue:** The girl next to me — a first year grind — would set her alarm on Monday morning at 4 am so she could get a couple extra hours of study in before beginning the week.

**Liz:** I had to do my medical rotation with an overachiever who memorized the entire chapter on Lupus and gave fourteen criteria for diagnosis.

**Sue:** Well, in third year I did an SICU rotation with an upperclassman who was going to be a surgeon, was doing his fourth SICU rotation, *and* was dating one of the nurses.

**Liz:** I had to do medicine with a partner who was married to our intern. He may not have liked her much, but he downright hated me.

**Sue:** I had surgery with the son of one of the staff surgeons. He was on his sixteenth surgery clerkship and had done four cardiac bypasses himself.

**Liz:** In medicine I had to work up eleven patients all of whom had rare diseases with incidence of less than one in four million.



**Sue:** I had to work up fifteen patients all with TB presenting with fifteen totally different groups of symptoms.

**Liz:** I had to work up fifteen patients all with syphilis presenting with fifteen totally different groups of symptoms *and* wash my hands between patients.

**Sue:** My visit made me read four chapters on face immersion as a cure for hiccups.

**Liz:** I had to prophylactically suction and transtracheally aspirate every ward patient on my floor in case someone developed fever at night.

**Sue:** Once my visit had me do prophylactic rectals on all the ward patients and I caused three cardiac arrests — and then I had to run all three codes.

*(Liz and Sue are strangling each other by now)*

**Liz:** Hey, let's calm down.

**Sue:** Yes, yes.

**Liz:** Have some Maalox. *(swigs Maalox)*

**Sue:** Have some sherry. *(swigs sherry)*

**Both:** There, that's better.

**Sue:** Then there are internship decisions.

**Liz:** Talk about angst!

**Sue:** Whether one should stay in Boston and the Harvard system in order to remain among people who know you don't know anything, but were the ones who taught it to you . . .

**Liz:** . . . or leave Boston and prove the point. So how do we handle this anxiety?

**Both:** Leave, ignore it, regress.

**Sue:** Sure, you can "take a break," drop out for a year, and uh, study . . . *(Liz: study?)* uh . . . study architecture or something in France or someplace.

**Liz:** Or you can go away on retreats and relate to each other.

**Sue:** Relate? Yeh, I'll bet. Or you can become *compulsive*, turn on, and avoid the rest of life.

**Liz:** Is it really true that the brownnoses have found a way to avoid having to go to the bathroom more than once a month in order to save valuable study time?

**Sue:** Who knows?

**Liz:** And then you can deny, regress, and subliminate.

**Sue:** Love that psychiatry.

**Liz:** You can run the Boston Marathon . . .

**Sue:** Trash Vanderbilt Hall. *(Ah, the good ol' days of water and shaving cream fights.)*

**Liz:** Or use drugs. *(salutes Maalox)*

**Sue:** Alcohol *(salutes the sherry)*

**Both:** . . . Or just violence. *(They strangle each other.)*

**Liz:** What could be done about this anxiety anyway?

**Sue:** Well, we could attack it on societal, familial or academic levels.

**Liz:** We could restructure society from the bottom up, eliminating competition and egocentricity.

**Sue:** Garbage. All you have to do is start a major world war. Bomb someplace and probably even medical students will stop being anxious about themselves.

**Liz:** Families could do their part too. Parents could start encouraging



their kids to become forest rangers instead of doctors.

**Sue:** We could convince moms that pediatrics is almost as good as orthopedic surgery, and get Mrs. Portnoy to lay off Stanley and get back to the kugel.

**Liz:** Or the Medical School itself could work with the problem.

**Sue:** You mean support from the Dean?

**Liz:** Who? No, daily TM sessions with Herb Benson.

**Sue:** Or maybe Harvard could try and forget the fact that we would have come here regardless. Sure, a Harvard degree is worth an ulcer or two, or even Zollinger-Ellison maybe, but Maalox is expensive and I already owe \$25,000.

**Liz:** Yeh, Harvard may come around and treat us nicely as an experiment — they could even write it up in the *New England Journal of Medicine*.

**Sue:** Sure, "Reduction of Stress in a Captive Population."

**Liz:** You think so?

**Sue:** Well . . .

**Liz:** Maybe . . .

**Sue:** Well . . .

**Liz:** No, huh?

**Sue:** Probably not. Harvard's not gonna change, Mrs. Portnoy's not gonna change, and they're not gonna start a war for us.

**Liz:** We're probably stuck with our ulcers for now. But we try and handle the anxiety ourselves, and we don't do so badly given the situation.

**Sue:** By the way, thanks for sitting up last night with me and practicing this speech. I was so worried.

**Liz:** No problem.



## The Glamour of Medicine

The last time I attended a Harvard graduation was in 1967 when I received my M.B.A. from the Business School. In the twelve years since, I left a career on Wall Street to begin medical school because I thought that the concerns in medicine were more significant than those in business. The issues facing me now are different in many ways and they are more formidable. Mistakes in medicine may involve less money than those in business but they can be more costly.

But that was what I asked for — challenges, stakes, and outcomes that would in some ways be more meaningful. I entered medical school with a great deal of idealism, putting what was left of my materialism in the bank. My expectations had been formed in part by society's image of a doctor and by what the media promised me.

Marcus Welby has time to spend one hour minus commercials with each patient and cure every one. So what if at twenty-five dollars an hour, and considering re-runs, he only makes five hundred dollars a year? On "Medical Center" the doctors wear Gucci greens and the hospital looks like it's out of that famous magazine, *Hospital and Garden*. The surgeons on "MASH" save patients, nurses, and Korea, simultaneously.

How come I found myself at 4 am on F Main of the Peter Bent Brigham Hospital, my hair disheveled, wearing brown Oxford shoes, and trying to start an IV in a 300 pound patient who kept calling me "waitress," "waitress"? A show about these exploits would receive poor Nielson ratings; human suffering would be alleviated only if I went to sleep.

My idealism was tempered by the realization that the daily and nightly work of medicine is often tedious. But if the means may not be glamorous, at least the ends must be rewarding. Clearly life and death are more important than stocks and bonds. But this is

a naive comparison since the efforts of medicine often have no impact on the balance of life and death. The dramatic saves in medicine are few and far between and very often what we do has little influence on the course of a disease. I learned that medicine is not only less glamorous and less heroic than I thought but, more important, I realized that heroics and glamour don't matter very much. What I thought was maturity when I first came here was perhaps just my age, some sophistication, and owning an American Express card. Facing illness, suffering, and death in my patients and in my own family clearly changed my perspective and values. I'm finding more satisfaction in the daily caring for individuals, which can be quite significant.

It is difficult for me to assess the differences between my experiences and those of my classmates, most of whom are younger. In the end, the

backgrounds and expectations we bring here may not matter. We all matured a great deal, together and separately. Nothing really prepares one for the experience here, which I think is more intense than that of any other professional school. From the routine, the disappointments, the sometimes terrifying issues and responsibilities, we all have to choose our degree of involvement and find the areas most satisfying to us.

As for glamour, hopefully the fantasy of what a doctor represents will not obscure the reality of what we can do and the hard work and frustrations won't dampen our idealism. My perspective has changed as I realize what I do may not be as earthshaking and romantic as I once hoped, but some of it may be important to the individuals whose lives I touch. It is different from Wall Street, but it's not "MASH." It's medicine and it's people and it can be pretty good.

Eve J. Higginbotham

## And Yet Another Challenge

During my years at Harvard, it has become increasingly evident that the status of minority students is far from secure. From defending our abilities against certain professors' opinions concerning the quality of black physicians, to protecting the continuation of the Minority Admissions Subcommittee subsequent to the Bakke decision, we have been forced to deal with issues of survival.

For twenty years after the Supreme Court's decision in *Brown versus the Board of Education* in 1954, the number of black physicians hovered around 2.2% of the total number of physicians. America was graduating annually only 166 black physicians for 10% of the population nationwide, a number less than our graduating class. Not until the assassination of Dr. King and the ensuing student unrest and agitation of the late '60s did administrators feel compelled to increase the numbers of minority students as well as women. By 1975 those once pitiful

numbers of underrepresented peoples had shown hopeful signs of growth. Blacks, constituting the largest racial minority, increased their ranks by a factor of 4, mainland Puerto Ricans by 3, American Indians by 5.5, Mexican Americans by 11, and women by 3.<sup>2,5</sup> That was the situation in 1975.

Admittedly, conditions have improved since the 1950s, but these facts should not invite a spirit of complacency. Recent statistics indicate a critical decline in minority enrollment, which threatens to restore the system of tokenism existing prior to the 1960s. Although total enrollments in American medical schools increased in 1979 by 2% over the previous year, the percentage of all minority students in first year classes dropped from a high of 10% in 1973 to 8.8% in 1978.<sup>3</sup> The hope of 1968 became the disappointment of 1978.

Racial minorities and women hold a double duty — a commitment to themselves and to those they repre-



sent — to excel in their chosen fields and to ensure the continued existence of both groups in medicine. In 1967, Dr. Martin Luther King wrote, "After 348 years, racial injustice is still the [black people's] burden and America's shame . . . He who starts behind in a race must forever remain behind or run faster than the man in front. What a dilemma! . . . It's a call to do the impossible . . . And yet there are times when life demands the perpetual doing of the impossible."<sup>4</sup>

What are some of the inequities that highlight our dilemma? For years preferential admission to professional schools was granted to children of alumni, faculty, friends of institutions and legislators. During the 1960s, race as a factor was added to the preexisting set of nonacademic biased selection criteria — a consideration recently challenged by the Bakke decision. This decision threatens to hinder further progress in remedying declining statistics. The disparities in medical school admissions are reflected in national health care delivery ratios. There is only one black physician to 4,100 black persons and only one Mexican American physician to 20,000 compared with a ratio of one to 538 for white persons.<sup>1</sup> Decreasing numbers of M.D. candidates will further serve to accentuate these discrepancies. Admittedly, more minority physicians may not solve the problem of improving care for minorities in the inner city, though they should ameliorate the situation. At this point even amelioration is social gain.

How do we solve the problem? The solution will be found neither in the passive acceptance of declining numbers nor in the journals and textbooks of our profession. We can increase minority enrollment by intensifying our efforts to recruit and retain degree candidates. Young people must be exposed at an earlier age to role models in the profession and be able to attend better secondary schools to nurture their talents and prepare them to accept leadership roles. The value systems of different racial groups in our society have to be included in the medical curriculum so that there is better rapport between faculty and students. And finally, the funds must be found for financial aid.

These solutions are not solely the concern of minorities. They represent



a challenge to everyone sensitive to the development of a socially responsive medical profession. Medical institutions should not be forced into the defeatist pattern of matching each forward step with two steps backward. As graduates of Harvard, we have the potential to set precedents for the remainder of the country. The greatest challenge, however, remains self-involvement.

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*Richard G. Rockefeller*

## Family Practice: Once More with Feeling

Not long ago, I am told, lamenting the deplorable state of family practice at Harvard Medical School was as much a part of class day oratory as the Hippocratic Oath. Both rituals have lapsed in these iconoclastic times, but the three of us, (I speak for myself and my fellow partisans Jim Distelhorst and Tom Campbell) have been graciously allowed to revive the topic. We do so gratefully, seriously, and a little awkwardly, fully realizing that our classmates, whose day this is, sealed their professional fates (for the next three years at least) on a rainy day two months ago. We are not out to win converts; we only wish to counterbalance in small part the neglect family practice has received in our medical curriculum and at the same time share our enthusiasm for it.

What is so special about family practice? The opportunity to contrib-



ute to a clear national need for well trained generalists is appealing, but accounts for only a small portion of our enthusiasm. The breadth of a family physician's training enables him or her to offer comprehensive, coordinated and continuous care regardless of the patient's age or illness, and this fosters a major goal of family practice, (to quote McWhinney), "... to put the person, in all his wholeness, in the center of the stage and not to separate the disease from the man, and the man from the environment — to practice a medicine that makes technology firmly subservient to human values, and maintains a creative balance between generalist and specialist." I suppose we can expect some personal reward from the highmindedness of this ideal, but much more from the opportunity its pursuit affords: to view the human experience from a uniquely broad perspective. Ours is the incredible privilege to share actively in all stages of the human life cycle, from the birth of a baby, through the various stresses and joys of life, to the death of a loved one.

While you will not get this impression around Boston, throughout the rest of the country family practice has become a dynamic force in shaping health care policy. Because the specialty is young it can challenge old assumptions and offer new perspectives on old problems. And because it is growing, it can add increasing im-

petus to those ideas. Since the establishment of the American Board of Family Physicians in 1969, family practice has become the second most popular career choice among American medical students. The specialty is alive and healthy . . . outside of Boston.

But at Harvard, family practice is a shambles, a fact that those of us committed to its ideals have felt acutely. We have neither a residency program nor departmental status. Without these guarantees of commitment by the School, federal funding is not available. This disadvantage completes a vicious circle, for attempts by the few remaining proponents to increase students' exposure are severely handicapped by lack of funds.

This was not always the case. From the 1950s until only a few years ago, the Harvard Family Health Care Program, under the direction of Drs. Charles Janeway and Robert Haggerty was vital, innovative and widely respected. Its unfortunate decline has been welcomed by many who feel there is no place for so clinical and broad a discipline at so academic and specialty oriented an institution. They may be right in the end, though for reasons more political than logical; but we believe a revitalization of family practice here would be a major addition to Harvard's medical education and could offer much to health care nationwide as well.

One obvious contribution would be broadening students' perceptions of valid career opportunities. More important, the perspective of family practice could go far to counteract the arrogance of technology and science to which we are so heavily exposed during most of our training. It is a perspective of humility which, as valuable and much touted as it is, has been rare in our clinical experience.

A family physician must learn to admit uncertainty and to deal with it as an everyday fact of a diverse practice that includes internal medicine, pediatrics, gynecology and sometimes obstetrics, office surgery, and a fair dollop of psychiatry. The limitations the family practitioner faces are no more substantial than those in other specialties, they are simply more tangible. There are comparatively few ailments whose complexity or rarity place them outside the scope of family medicine, but that can be satisfactorily treated by specialists other than surgeons. In subspecialty practice, however, you can be content that what you know and can do is at the limit of *human* knowing and doing, and thus more easily ignore how limited this is.

What can Harvard in its turn contribute to family practice? Harvard's very orientation to the basic sciences could be perceived as a valuable asset: it has been asserted that the next great frontiers of medical research will be in the realm of the primary care specialties, on the relationships between social milieu and illness, and on the chronic diseases of the so-called outpatient population. Research outside a controlled hospital or laboratory environment is expensive and difficult, requiring large-scale studies and multidisciplinary analysis well suited to the breadth of resources that Harvard, but few other institutions, can command.

On this last day of medical school, Tom, Jim and I would like to reiterate a plea to Harvard to upgrade the status of family practice, to improve educational opportunities and ultimately to move toward reestablishing a residency program. We recognize there are constraints that do not arise simply from ill will toward or ignorance about family practice; but with a strong commitment by the administration and faculty, such obstacles could be overcome.



## The Importance of Not Being Earnest

I thought we'd spend the next hour or two exploring some issues related to survival in medicine. After that we'll have a short quiz — but you needn't sign your name.

Being a medical student is a sometimes impossible situation, but there are various legal ways to cope. The most useful of these, I've found, is the ability to stand back and laugh at the situation — especially during rounds with the attending. The Harvard faculty is just chock full of laugh-a-minute people who like nothing better than to share a good joke with a student — as long as the joke is on the student. The joke and its sequella — the laugh — have had considerable historical importance. In the Bible, hardly the last word in humor, there is that memorable passage in Genesis where God turns to Sarah and says, "Nay but thou didst laugh."

Laughter is commonly indicated in the medical school experience. Think back over our first two years here, weren't they just like high school? We had the all-day classes with the same boring people, the lockers, the undone homework, the degradation, and above all, the gossip. The only thing missing was the Math Club meeting after school.

Only a fool would say we weren't well prepared for our first patient contact in Introduction to Clinical Medicine. Didn't we spend entire mornings listening to desperate harangues on key topics such as bungarotoxin, crico-arytenoid arthritis, and — my personal favorite — the plymphocyte? Somehow, something was lacking because when we did get to those first poor patients all we could offer them was a nervous smile and a sweaty four hour physical exam (and still we would forget to listen to the lungs). Looking back on my notes from those first tortured histories I took I find that I had written things like "enjoys peanut butter" and "neighbor has diabetes."

Contrast this bumbling to what other achievement-oriented people our age are doing. Most of them have jobs and command some degree of respect from their co-workers. Not us. During our third and fourth year rotations, every fourth Monday we became the new low-people on the clinical totem pole and even the janitor had to reorient us to the place, its power structure, and the whereabouts of the staff toilet. In the medicine clerkship (otherwise known as the Ox-Bow Incident) — an experience Kafka would have expressed interest in — we found ourselves in the awkward position of having to know beforehand what we had come to learn. A further challenge was avoiding brain death during visit rounds where a mere sneeze could set off a three hour infectious disease symposium on ox vs. naf.

These problems seem trivial compared to the tragedies we began to see our patients going through. Tension soon appeared as we realized that what patients expect oftentimes differs from what medicine can deliver.

How did we exorcise this tension? Some of us allowed compulsive tendencies to get hold. This group would

go home and label their dresser drawers — "socks, white"; "socks, black." Some just dropped out and gave up. You could find them watching "Happy Days" reruns with their patients during visit rounds. Others came into partial equilibrium with the system; I bet everyone has written that wonderfully sincere expression:

"Thank you for this interesting consult — will follow closely with you."

No matter what degree of success we have, we do need to take ourselves a little less seriously than we do. We must realize that despite our best efforts we often have very little to offer our patients. We need to accept — without guilt — what Freud (in a personal communication) describes as "gallows humor." I can't give you an example of this black humor because out of context it is not only not funny but downright ghoulish.

The philosopher Bergson, who is a million laughs in his own right, tells us that "... we laugh every time a person gives us the impression of being a thing." Unfortunately this happens often in medicine; people as things are absurd and depersonalized, and we can laugh at them. It is important to do so because it is often the only way to release the tension and even hostility that are created when we are helpless to ameliorate the sufferings of our patients. That to me is the importance of not being earnest. I'd love to go on but I'm afraid that I have to read up on naf vs. ox before internship.





Jill Stein provided two musical respites during Class Day exercises  
—"Golden Morning" and "Hospital Blues."

**HOSPITAL BLUES** by Jill Stein

*Verse*

The hos-pi-tal blues, I feel so con-fused I  
 ain't seen the day-light for days or-I - ent-ed times two and my  
 af-fect is blue one pre-vious-ly heal-thy fe-male well the  
 vi-sit de-clared my fund of know-ledge im-paired  
 one stu-dent needs stat T L C These hos-pi-tal blues got me

\* To be sung an octave lower than written

**Chorus**

I can't eat I can't sleep my bowels ain't moved in a week ain't had no  
 hug-gin had no kis-sin don't re-mem-ber what I'm mi-ss-in no dys-  
 ur-ia no hem-a-tur-ia no jaun-dice and no ict-er-us no  
 fev-ers head-aches chills don't smoke cig-arets don't take pills

*Second Verse*

My re-flexes are intact but the affect is flat  
 My muscles got diffuse atrophy and  
 When my team is rounding I'm already sundawning  
 how can I present without short term memory  
 Well in-ti-mi-dation don't aid my ed-u-cation  
 These hospital blues got me.

*Third Verse*

It's acute love deprivation  
 requiring stat resuscitation  
 I'll take it IM or IV, need some  
 lovin CPR to revive my achin heart  
 need me some old fashioned PT  
 No fevers headaches chills don't smoke  
 cigarettes or take pills,  
 but these hospital blues got me.



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